APPENDIX A

About Your Benefits: Health Care Benefits

SUMMARY PLAN DESCRIPTION

106

Effective Date: January 1, 2019

This Summary Plan Description

This is intended to provide summary plan descriptions of the following benefit plans and programs in which you may be eligible to participate:

- IBM Personal Benefits Program
- IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees, referred to herein as the "Plan" and which includes the following components:
  - IBM PPO
  - IBM PPO Plus
  - IBM Exclusive Provider Organization (EPO)
  - IBM PPO with Health Savings Account (HSA)
  - IBM Enhanced PPO with Health Savings Account (HSA)
- IBM Managed Pharmacy Program
- Care Management Program (consisting of the Condition Management and Care Coordination programs)
- IBM Mental Health Care Program (consisting of the IBM Managed Mental Health Care Program and the Employee Assistance Program)
- IBM Dental Basic and IBM Dental Plus
- IBM Vision Plan and EyeMed Vision Discount Plan
- Special Care for Children Assistance Plan (SCCAP)
- IBM Health Care Spending Account (HCSA) and IBM Dependent Care Spending Account (DCSA)
- IBM Adoption and Surrogacy Assistance Program
- Personal Financial Planning – IBM Money*Smart*

The official plan documents are the final authority and shall govern in all cases. The Plan Administrator retains exclusive authority and discretion to interpret the terms of the benefit plans described herein. IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the Company requires. Nothing contained in this book shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies.

Because of the need for confidentiality, decisions regarding changes to IBM's benefits plans, programs, practices or policies are generally not discussed or evaluated below the highest levels of management. Managers and their representatives below such levels do not know whether IBM will or will not change or adopt, for example, any particular benefit. Nor are they in a position to advise any employee on, or speculate about, future plans. Employees should make no assumptions about future changes or the impact changes may have on their personal situation until any such change is formally announced by IBM.

Edition Notice:
With respect to all Plans described herein, this book supersedes all Summary Plan Descriptions found in prior versions of *About Your Company, About Your Financial Future* and *About Your Benefits*, as well as their supplements. It provides cumulative, updated information as of January 1, 2019.

Employees with access to w3, the IBM intranet, should view *About Your Benefits* in the Formal HR Documentation to ensure they have the most current Summary Plan Descriptions. Employees without access may call the IBM Benefits Center – Provided by Fidelity at 866-937-0720 (TTY: 800-426-6537); outside the U.S. dial your country's toll-free AT&T Direct® access number, and then enter 866-937-0720.

Introduction

IBM BENEFITS PROGRAMS

Your IBM benefits are a key component of your total compensation and offer a broad foundation upon which you can build to provide for your needs and the well-being of your family. IBM continually reviews these programs and compares them with those of other organizations to maintain their competitiveness and ensure they reflect your needs.

We encourage you to become familiar with the coverage provided by IBM and the benefits options available to you. Then you can determine whether to supplement your coverage through IBM with additional individual coverage.

You can also help IBM in the way you use the Company's health care benefits programs. By doing your part as a health care consumer to contain health care costs, you not only reduce your expenses but also help make it possible for IBM to continue to offer these valuable benefit plans. For example, while you should always seek professional medical help when it is needed, you can ask questions about the treatment programs your doctor prescribes and utilize a Voluntary Nurse Helpline (if available) for information. You can also use network providers and facilities and look into alternative approaches to hospitalization or surgery that may be covered by the plans. And, of course, nothing is better than the overall advantages of maintaining a healthy lifestyle.

All treatments, services or supplies must be medically necessary and appropriate for the condition being treated, as determined by or on behalf of the Plan Administrator. Except where applicable state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" means those health care services provided according to generally accepted standards of practice in the medical or dental professions and is further described in "What's Covered under the Medical Plan Options" section.

ELIGIBILITY

Unless otherwise noted, the plans described in this book are available to all regular full-time, regular part-time and retiree supplemental employees of International Business Machines Corporation, or those subsidiaries of IBM authorized to participate in the plans, regularly assigned in the United States of America, its territories and possessions and the Commonwealth of Puerto Rico.

Except as specifically noted with respect to supplemental employees (who are eligible only for medical, dental and vision options, the Employee Assistance Program and the flexible spending accounts), the plans are not available to other categories of employees, such as supplemental employees. Please refer to the eligibility section of each program for details on who is eligible to participate.

IF YOU HAVE QUESTIONS

If you have any questions about your IBM benefit plans, or the information provided here, contact the IBM Benefits Center – Provided by Fidelity at 866-937-0720 (TTY: 800-426-6537). Outside the U.S. dial your country's toll-free AT&T Direct® access number, then enter 866-937-0720.

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Contacts

PLAN	CONTACT	PHONE NUMBERS	WEB SITE
MEDICAL			
IBM PPO IBM PPO Plus IBM Exclusive Provider Organization IBM PPO with HSA IBM Enhanced PPO with HSA	Aetna Inc.	855-888-9046 International: 860-273-0123 TTY: 800-628-3323	www.aetna.com
	Anthem Blue Cross and Blue Shield	800-238-6597 International: 800-238-6597 Hearing Impaired members can dial 711 and provide the Anthem Customer Service number to the relay operator	www.anthem.com
Health Plan Administrators depend on where you live. See "Health Plans by Regional Location" for details.	UnitedHealthcare	877-222-4261 International: 877-265-9200 TTY: 877-218-7138	www.myuhc.com
MEDICAL: Out-of-Area Options			
IBM PPO IBM PPO Plus IBM PPO with HSA IBM Enhanced PPO with HSA	UnitedHealthcare	877-222-4261 International: 877-265-9200 TTY: 877-218-7138	www.myuhc.com
MEDICAL: HMOs			
Health Maintenance Organizations (HMOs)	See the Health Plan Detail Sheets for phone numbers and web site addresses		
GLOBAL HEALTH			
IBM Global Assignee Medical Plan	Cigna Global Health Benefits	800-441-2668 International: Use the country's AT&T code or 302-797-3100 (reverse charges accepted) Direct Fax: (302) 797-3150	www.Cignaenvoy.com
TRANSITIONAL MEDICAL			
Transitional Medical Program (TMP)	IBM Benefits Center – Provided by Fidelity	866-937-0720 International: Dial AT&T Direct Service Access number, then 866-937-0720 TTY: 800-426-6537	Not available
PRESCRIPTION DRUGS			
IBM Managed Pharmacy Program	CVS Caremark	855-465-0030 TTY: 800-863-5488	www.caremark.com

PLAN	CONTACT	PHONE NUMBERS	WEB SITE
MENTAL HEALTH/SUBSTANCE USE			
IBM Managed Mental Health Care Program	Optum by United Behavioral Health	800-445-9720 International: 267-216-3277 TTY: Dial 711 and enter 800-445-9720	www.liveandworkwell.com Access Code = IBM
Employee Assistance Program	Optum by United Behavioral Health	800-445-9720 International: 267-216-3277 TTY: Dial 711 and enter 800-445-9720	www.liveandworkwell.com Access Code = IBM
CARE MANAGEMENT			
Disease Management Program	Contact the health plan directly		
Care Coordination Services	Contact the health plan directly		
DENTAL			
IBM Dental Plus IBM Dental Basic	MetLife	800-872-6963 International: AT&T Access Code + 800-962-1401 TTY: 800-843-2896	www.metlife.com/mybenefits
VISION			
Vision Plan	Anthem Blue View Vision	855-765-4552 TTY: 866-308-5375	www.anthem.com Employer ID = IBM
EyeMed Vision Discount Plan	EyeMed Vision Care	855-245-0621	
FLEXIBLE SPENDING ACCOUNTS			
Health Care Spending Account (HCSA)	Acclaris	888-880-2775 Fax: 813-830-7900	www.acclarisonline.com
Dependent Care Spending Account (DCSA)	Acclaris	888-880-2775 Fax: 813-830-7900	www.acclarisonline.com

VOICE RESPONSE UNITS AND CUSTOMER SERVICE REPRESENTATIVES

The Voice Response Units (VRUs) and toll-free numbers for customer service representatives are provided as a convenience. While there is every intention to answer your questions accurately, responses are necessarily given in summary form and may not fully anticipate or describe all nuances surrounding each question. Errors due to miscommunication by either party or other causes are also possible. In any event, neither the VRUs nor the customer service representatives are authorized to give you binding advice or to change the terms of the plans.

All details furnished by the VRUs or customer service representatives, including eligibility for benefits, must necessarily be governed by the availability of correct personnel data and the provisions contained in *About Your Benefits* and other plan documents, as they might be amended and in effect on the date for which benefit coverage is sought. Plan documents, insurance policies, IBM's corrected records, other controlling documents or the applicable law will control in the event of any conflict between the terms of the Plans and the information provided by the VRUs or customer service representatives.

Before calling a customer service center or making a decision based on information you receive from the VRUs or customer service representatives, you should review *About Your Benefits,* your employment records and other plan documents which are available upon request. You may request written information from the Office of the Plan Administrator, IBM Benefits Center, PO Box 770003, Cincinnati, OH 45277-1060.

IBM BENEFITS CENTER AT 866-937-0720

To help you with enrollment, general benefits information and questions, the IBM Benefits Center – Provided by Fidelity is available to you virtually 24 hours a day, 7 days a week by phone or online through NetBenefits℠ at netbenefits.com/ibm. The Benefits Center is administered by Fidelity Investments, the service provider for administration of IBM's benefit plans. You may call the voice response unit (VRU) for automated information at any time. Service representatives are available business days (excluding holidays recognized by the New York Stock Exchange except Good Friday) between 8:30 a.m. and 8:30 p.m., Eastern time.

Hearing Impaired Access

Dial 800-426-6537, available on business days (excluding holidays recognized by the New York Stock Exchange) between 8:30 a.m. and 8:30 p.m., Eastern time.

Overseas Access

Dial your country's toll-free AT&T Direct® access number, then enter 866-937-0720.

NETBENEFITS AT NETBENEFITS.COM/IBM

Fidelity NetBenefits® is your source for benefit transactions and information virtually 24 hours a day, 7 days a week. Each time you log in to NetBenefits you need to enter your Social Security number and Personal Identification Number (PIN). If you prefer not to use your Social Security number, you can establish a Customer ID by clicking the "Create or Change your Customer ID" link on the NetBenefits login screen or by calling the IBM Benefits Center – Provided by Fidelity.

Establishing a PIN

When you access NetBenefits or call the IBM Benefits Center, you will need a Personal Identification Number (PIN). Your PIN provides another level of security to ensure that only you can access your benefits information. For your protection, keep your PIN confidential.

You can establish your PIN directly on NetBenefits at netbenefits.com/ibm or by calling the IBM Benefits Center at 866-937-0720. Your PIN cannot be your date of birth or your Social Security number. It also cannot contain multiple repetitive digits or be in ascending or descending order.

NETBENEFITS MOBILE APP

If you prefer, you can enroll or check your benefits elections right on your smartphone. Download the NetBenefits® mobile app from the App Store℠ or Google Play™ Store and get access to your IBM benefits.

CAFEWELL AT CAFEWELL.COM/IBM

CaféWell is your one-stop-shop for benefits information, the Health Incentive and Rewards Program and wellbeing resources. CaféWell offers a personalized experience with program recommendations unique to you and the capability to deliver to you the right information at the right time to support your health and wellbeing. In addition, it offers access to your health plan benefits. Visit www.cafewell.com/ibm to create your account and begin taking advantage of this valuable resource.

YOU AND IBM WEB SITE AT W3.IBM.COM

IBM's intranet contains information about all of your employee benefit programs, including summary plan descriptions, forms and other resources. Throughout this SPD, IBM's intranet will be referred to as "w3."

About the Personal Benefits Program

About the Personal Benefits Program

YOUR PERSONAL BENEFITS PROGRAM CHOICES

The Personal Benefits Program is a "flexible benefits" plan that allows you to personalize your health care coverage to best fit your unique situation. Depending on your eligibility, the Personal Benefits Program provides you with a choice of options, as highlighted below.

Option	Description
MEDICAL COVERAGE — All options include Mental Health/Substance Use and Prescription Drug Coverage	
IBM PPO and IBM PPO Plus	Coverage for medical, surgical, prescription drug and hospitalization expenses from in-network providers only; out-of-network services will generally not be covered (for more details see *"Out-Of-Network Medical Coverage"*).
IBM Exclusive Provider Organization (EPO)	Coverage for medical, surgical, prescription drug and hospitalization expenses from in-network providers only; out-of-network services will generally not be covered. There are fixed copayments for Inpatient and Emergency room services.
IBM PPO with Health Savings Account (HSA) and IBM Enhanced PPO with Health Savings Account (HSA)	Coverage for medical, surgical, prescription drug and hospitalization expenses from in-network providers after you meet a high annual individual/family deductible; also allows you to contribute to a Health Savings Account (HSA). Out-of-network services will generally not be covered (for more details see *"Out-Of-Network Medical Coverage"*).
Health Maintenance Organization (HMO) *Depending on geographic location*	A managed care option that provides coverage for medical, surgical, prescription drug and hospitalization expenses from in-network providers only; out-of-network services will generally not be covered.
No Coverage	Waive coverage for the plan year and receive $30 cash back per month
DENTAL COVERAGE	
IBM Dental Plus	Comprehensive coverage for preventive and diagnostic treatment, basic and major restorative services up to an annual maximum benefit of $2,000 per covered individual. Orthodontia is covered up to a lifetime maximum of $2,500. Orthodontia services are not applied to the annual maximum.
IBM Dental Basic	Basic coverage for preventive and diagnostic treatment and basic restorative services only, up to an annual maximum benefit of $500 per covered individual.
No Coverage	Waive coverage for the plan year.
VISION COVERAGE	
IBM Vision Plan	Coverage for routine eye exams and eyewear both in and out of the Anthem Blue View Vision network.
EyeMed Vision Discount Plan	A discount program, provided at no cost to you, for eye exams, eyewear and other vision care services from network providers.
No Coverage	Waive coverage for the plan year.
FLEXIBLE SPENDING ACCOUNTS	
Health Care Spending Account	Contribute from $10 per month up to $2,650 annual maximum ($220.83/month if participating for 12 months) on a pretax basis for eligible out-of-pocket health care expenses recognized by the IRS.
Dependent Care Spending Account	Contribute from $20 up to $5,000 annual maximum ($417/monthly if participating for 12 months) on a pretax basis for eligible out-of-pocket dependent care expenses recognized by the IRS so that you, and your spouse if applicable, can work.

Note: Employees who are on International Assignment and are designated as eligible will be enrolled in the IBM Global Assignee Medical Plan and receive their medical, dental, vision, pharmacy and mental health benefits through Cigna Global Health Benefits.

ELIGIBILITY

IBM requires Social Security numbers be provided for all employees and dependents in order to be enrolled in IBM health benefits so IBM or its Plan Administrators can perform Coordination of Benefits validations and report data to the Centers for Medicare and Medicaid Services as required.

Eligible Employees

Eligibility begins on your first day of regular employment and there are no pre-existing condition exclusions. You are eligible to participate in the Personal Benefits Program for coverage under the IBM medical, dental and vision options, the Employee Assistance Program (EAP), Health Care Spending Account (HCSA) and Dependent Care Spending Account (DCSA) if you are a:

- Regular full-time or regular part-time employee of IBM receiving wages reportable on Form W-2 through IBM payroll, its subsidiaries authorized to participate in the Plans, and
  - You are regularly assigned in the United States of America, one of its territories or possessions or the Commonwealth of Puerto Rico and
  - You are in active status and actively at work.
- Regular full-time or regular part-time employee, as described above, on an approved leave of absence with benefits.*
- Long-term supplemental employee.
- Retiree supplemental employee (not eligible for the IBM Health Care Spending Account or the Dependent Care Spending Account).

* If you go on a leave of absence, you are no longer eligible to participate in the DCSA. You will resume eligibility once you return to regular full-time or regular part-time status. If you are participating in the HCSA, you need to contact the IBM Benefits Center – Provided by Fidelity to discontinue participation in the HCSA. If you do not, you will continue participation and be billed for your contributions on a post-tax basis.

If You Live In Hawaii

The Hawaii Prepaid Health Care Act requires that all employees in Hawaii working at least 20 hours a week, for 4 consecutive weeks, must be enrolled in coverage. Therefore, in addition to the above, non-regular employees in Hawaii who meet this requirement will be eligible to participate in the Personal Benefits Program. In accordance with Hawaii state law, any employee who resides in Hawaii and wishes to decline (opt out) of medical coverage must complete and sign Hawaii Form HC-5, and submit the completed form to the IBM Benefits Center – Provided by Fidelity. This form is available on the following Hawaii government web site: http://www.hawaii.gov/labor/formsall.shtml and is listed under "Prepaid Healthcare." The completed form may be mailed or faxed to the IBM Benefits Center. If the form is not submitted, eligible employees will be automatically enrolled for employee-only coverage in the IBM Self-Managed Plan (Hawaii).

Health care coverage for employees in Hawaii who become disabled from working will be continued at the same contribution rate for a period of three months following the month in which the employee became disabled from working.

Please contact the IBM Benefits Center to request a copy of the *Supplement to About Your Benefits for Hawaii Employees Enrolled in the Self-Managed Plan (Hawaii).*

If You Are Receiving STD Benefits
Employees receiving benefits under the IBM Short Term Disability (STD) Plan are also eligible for coverage under the IBM Medical and Dental Benefits Plan.

If You Are on International Assignment
Employees who are designated as on an International Assignment, or a Global IBMer Assignment under the Global Mobility Framework or as a 100% Travel Auditor deemed to be eligible for the IBM Global Assignee Medical Plan and receive medical, dental, vision, pharmacy and mental health coverage through Cigna Global Health Benefits. Go to www.CignaEnvoy.com to review the benefits at a glance document or the plan certificate, which provides full details on the plan provisions.

If You Are on Long-Term Disability
Eligibility for employees receiving monthly benefits under the IBM Medical Disability Income Plan (MDIP) or the IBM Long Term Disability Plan (LTD), and their dependents, is determined under the IBM Benefits Plans for Retired Employees. Please refer to the Summary Plan Description *About Your Benefits: Post Employment* for eligibility criteria and descriptions of health care coverage available to you.

Eligible Spouse/Domestic Partner

- Your spouse (same or opposite sex), if the marriage met the laws of the jurisdiction in which it was entered into.
- Your domestic partner who meets IBM's eligibility criteria as defined later in this section.
- Your common-law spouse may be eligible in certain circumstances. To meet the eligibility criteria to add a common-law spouse to your health coverage, you must:
  - Reside in a state that recognizes common-law marriage
  - Openly represent yourselves as husband and wife to government and tax authorities as well as to your relatives, friends, neighbors, coworkers and acquaintances with whom you associate. It is expected that you file your income taxes as "married"
  - Change your status to "married" at IBM and ensure that your IRS form W-4 reflects "married"
  - Not be legally married to another person

Eligible Children
An eligible child maintains eligibility up to the end of the month in which the child reaches his or her 26th birthday as long as he or she continues to meet all other eligibility requirements where applicable. In no event will any child who is a ward of the state or a foster child be eligible under the Plan.

Your eligible children include:

- Your natural and legally-adopted children up to age 26
- Your stepchildren up to age 26 (including the children of your same-sex spouse or your eligible domestic partner)
- Other Children up to age 26. Other Children means children for whom IBM determines that you have been granted permanent legal guardianship by a court of law. You will be considered to have permanent legal guardianship if both of the following requirements are met:
  - The child is subject to a court order under which you, the employee, have been granted permanent legal guardianship of the child's person and property.

- Permanent legal guardianship of the child's person and property must be obtained through a court of law. IBM requires that the court papers specifically state the guardianship is permanent and is for both person and property, even if the child does not own any property when the permanent legal guardianship is obtained. A letter signed by one or both natural parents, even if notarized, will not suffice as evident of permanent legal guardianship. Guardianship may not be joint guardianship with the child's natural parents.
- A Parent/Child Relationship exists between an employee and a child when, in the absence of the natural parents (except as provided below), the employee has both the rights and responsibilities of a parent.
- Court-ordered custody or legal guardianship does not in itself satisfy this requirement.
- Generally, a parent/child relationship will not be found to exist for the purposes of the Plan while the child has a known natural parent. However, in determining whether a parent/child relationship exists, the Plan Administrator may disregard a natural parent in certain circumstances (e.g., if the child's natural parents are incarcerated, institutionalized, a danger to the child (a court order of protection with no visitation must be provided), or their whereabouts are unknown).

Note: Other children determined to be eligible before January 1, 2009, remain eligible as long as they continue to meet the requirements noted above.

A dependent child who meets the above eligibility requirements must also meet certain tax requirements to also be eligible for tax-free coverage. Refer to the "IRS Requirements Regarding the Tax-Free Status of Dependent Children" section for further information regarding a dependent's status for tax-free coverage. It is your responsibility to notify the IBM Benefits Center – Provided by Fidelity if any eligible child does not meet the IRS requirements as stated in the above referenced section.

If You Have a Child with a Disability

Your mentally or physically disabled child may be eligible for coverage beyond age 26 if IBM determines, on the basis of the child's condition, that your child is:

- Mentally or physically disabled and the disability existed prior to the child's 26th birthday
- Incapable of self-support due to the mental or physical disability
- Unmarried
- Receiving over 50% of support from you, the employee, for maintenance and support (SSI or SSDI income may be used in determining whether your child is principally dependent upon you)
- The child must have been eligible under the Plan immediately before reaching age 26, or in the case of an employee hired after the child has attained age 26, a child who would have been eligible under the Plan if the employee had been employed by IBM at such time

If you think your child will meet the above criteria at age 26, you *must* request continuation of IBM health benefits by completing the "Application for Coverage of Disabled Dependent Child" and submitting it to the IBM Benefits Center – Provided by Fidelity within the window of time that begins 60 days prior to the child's 26th birthday and ends 60 days after the child's 26th birthday. Applications are available on w3, NetBenefits or by calling the IBM Benefits Center.

Once your application is approved, coverage will remain in effect for as long as you remain an eligible employee and your dependent meets the eligibility criteria as determined by the Plan and as may be modified thereafter. It is your responsibility to notify the IBM Benefits Center to remove your child if he or she no longer meets the eligibility criteria for continued coverage beyond age 26.

You may opt out or waive coverage for one year for your dependent child and re-enroll your child during the next or subsequent annual enrollment period as long as you, the employee, and your child continue to meet the eligibility criteria. Once any of the five conditions (outlined in the bullets above) is not met by a child beyond the age of 26, coverage will be discontinued and will not be reinstated, even if later the child again meets all or any of the five conditions.

Eligibility for a Same-Sex Domestic Partner
Information regarding the definition of a domestic partner and about covering a domestic partner is available by contacting the IBM Benefits Center – Provided by Fidelity or reviewing a copy of the *Spouse and Domestic Partner Information Guide*, available from NetBenefits and w3.

Please note that enrolling a domestic partner has certain tax implications. For details, see "Paying for Your Benefits" later in this section.

Equal Benefits Ordinances (EBOs) – Eligibility for Same-Sex and Opposite-Sex Domestic Partner
The State of California (and other localities in California) and the City of Seattle, Washington implemented regulations known as "Equal Benefits Ordinance" (EBO). These regulations require employers who are engaged in contract work within the State or California (or other localities in California) or the City of Seattle, Washington to provide/extend health and other employer benefits equally to those employees who work on state or municipal contracts (and their same-sex or opposite sex domestic partners) when such contracts contain EBO provisions.

Information regarding Equal Benefits Ordinances (EBOs) is available by contacting the IBM Benefits Center – Provided by Fidelity or reviewing a copy of the *Spouse and Domestic Partner Information Guide,* available from NetBenefits and w3.

Your Responsibilities Regarding Eligibility
As a condition of eligibility for benefits, you must follow and allow the Plan Administrator and health plan administrators to follow the operating procedures established for the functioning of the Plans. This includes, for example, the furnishing of Social Security numbers to health plan administrators and the furnishing of reports on benefit payments and precertifications to Plan participants.

It is your responsibility to ensure the data on your eligibility record is current. This includes notifying IBM of a change in a family member's eligibility status as well as address updates. You must enroll new eligible family members and/or notify IBM of a change in a family member's eligibility status within 30 days of the event.

To enroll or change a family member's status, login to NetBenefits or call an IBM Benefits Center – Provided by Fidelity representative. Addresses must be updated in Workday, available on w3. If you are not actively working, call the IBM Benefits Center to update your address. Other group health plan coverage information should be updated through the health plan of the plan in which you are enrolled.

IBM's Right to Verify Eligibility
IBM reserves the right to require documentation to support the eligibility of any dependent enrolled in an IBM benefit plan, such as a marriage certificate, affidavit of domestic partnership, a copy of a recent Federal Tax Return (e.g., 1040), birth certificate or adoption papers. The Plan Administrator may require verification that your enrolled dependents meet the eligibility requirements described previously. If the Plan Administrator learns you have not notified the IBM Benefits Center – Provided by Fidelity regarding an enrolled dependent who does not meet IBM's eligibility criteria for coverage or does not meet IRS eligibility requirements for tax-free coverage, that dependent will be removed from coverage and will

remain ineligible for future coverage. The Plan Administrator has the right to take additional actions, as explained in "Fraudulent Enrollments," below.

The Plan Administrator has the sole discretion to make the final decision with respect to eligibility under the Plan. The decision will take into account any factors determined to be relevant within the intent of the Plan and consistent with the tax-qualified status of the Plan.

Fraudulent Enrollments

It is a crime to knowingly, and with intent to injure, defraud, or deceive the company, provide any fraudulent information, including enrolling an individual whom you know is not eligible to participate in the IBM health plans or continuing to maintain coverage for an individual whom you know is not eligible. These actions, as well as the submission of materially false information, may result in rescinding your coverage under the IBM health plans, retroactive to the date of the fraudulent act, and you may be subject to prosecution and punishment under state and/or federal law. The IBM health plans would terminate coverage of a participant or beneficiary for a reason such as fraud.

When You Are No Longer Eligible

If you stop being an eligible employee — for example, you transfer to an ineligible job classification or separate from employment — your participation in the Personal Benefits Program will end. You may be eligible to continue your medical, dental, vision and Health Care Spending Account coverage. For more information, see "Transitional Medical Program (TMP)" in the Administrative Information section.

If you are leaving the Company and meet certain age and service requirements, you may be eligible to continue certain benefits coverage (after or instead of Transitional Medical Program coverage), and/or to access your Future Health Account (to be used for assistance in paying premiums for IBM medical, dental and vision benefits). See *About Your Benefits: Post Employment* and *About Your Benefits: Future Health Account (FHA)*, which can be accessed from w3.

In the event you become eligible again to participate in the Personal Benefits Program (for example, you are rehired), you will generally be treated as a new employee and must re-enroll in your benefits.

ENROLLING IN YOUR BENEFITS

Coverage Tiers

You may elect different coverage levels for different options within the Plan, but you cannot elect to cover eligible family members under an option in which you are not also enrolled. Each coverage option available to you will have a monthly contribution amount, with a separate amount for employee, spouse/domestic partner and each child.

You designate in your election the individuals you will cover:

- Yourself
- An eligible spouse/domestic partner
- Each eligible child

You elect the types of coverage and the dependents you are covering, and then add up the separate monthly contribution amounts. You will pay the "child" amount for any eligible children regardless of their age. Only an eligible spouse/domestic partner is subject to the "spouse/domestic partner" amount.

IBM requires Social Security numbers be provided for all employees and dependents in order for them to be enrolled in IBM health benefits so IBM or its Plan Administrators can perform Coordination of Benefits validations and report data to the Centers for Medicare and Medicaid Services as required.

HOW TO ENROLL

1. Log in to NetBenefits at netbenefits.com/ibm or on the NetBenefits app. If this is your first time visiting the site, you will be prompted to create a PIN.
2. From the Health & Insurance tab, select My Enrollments and follow the screen prompts to enter information about your eligible family members whom you wish to enroll.
3. Make your benefits selections through your Enrollment Worksheet.
4. Click "Save All Elections" to process your selections. Review and print the confirmation screen.
5. You will receive a confirmation e-mail, which you should review for accuracy.
6. If you prefer to enroll by phone, call an IBM Benefits Center – Provided by Fidelity service representative.

Note: You, your spouse/domestic partner and dependent children must be enrolled in order to receive IBM medical, dental and vision coverage.

Enrolling In Your Benefits as a New Hire

If you are a new employee, you will receive an e-mail notice directing you to NetBenefits to review your personalized plan options and costs within a few days of your date of hire. *You must enroll by the enrollment deadline date indicated in your materials.* The options you select and their associated contributions will be retroactive to your date of hire.

If you enroll by the enrollment deadline, your elected coverage will be effective as of your date of hire. If your date of hire falls within a pay period, you will be charged the full amount for that pay period. Eligible medical, dental and vision expenses incurred after your date of hire, but before you make your enrollment election, will be reimbursed under the provisions of the options you enroll in.

Once enrollment is completed, your elections will remain in effect until the end of the plan year. You may not change your elections until the next annual enrollment unless you experience a qualified status change (see "Changing Coverage Due to a Qualified Status Change" in the Administrative Information section).

If You Do Not Make Your Elections by the Deadline

If you do not make your elections by your enrollment deadline, you will be deemed to have opted out of medical, dental and vision coverage and the Health Care Spending Account and Dependent Care Spending Account for the remainder of the plan year. You also will be deemed to have opted out of the Health Incentives and Rewards Program.

Annual Enrollment

Each year during annual enrollment, usually held in the fall, you will have the opportunity to review your benefits elections and make changes to your medical, dental and vision coverage for yourself and your eligible family members. If eligible, you also may elect to contribute pretax dollars from your pay to the Health Care Spending Account (HCSA) and/or the Dependent Care Spending Account (DCSA).

Your new elections will remain in effect for the upcoming plan year (normally January 1st through December 31st), unless you experience a qualified status change which permits you to make a change during the year. Permissible changes outside of the annual enrollment period, such as adding a new dependent, must be made within 60 days of the event by contacting the IBM Benefits Center – Provided by Fidelity. If you do not make the election within 60 days of the event, you will have to wait until the next annual enrollment period. For more information about qualified status changes, see "Changing Coverage Due to a Qualified Status Change" in the Administrative Information section.

If you do not make an election during annual enrollment, you will automatically be enrolled in the same medical, dental and vision coverage you had in the plan year just ending (provided the same plans continue to be available), but with no contributions to the Health Care Spending Account and Dependent Care Spending Account for the upcoming plan year.

HOW TO ENROLL A NEW DEPENDENT

You must enroll a newly-eligible family member in your benefits options, even if your monthly contributions will not increase because you are already enrolled in the maximum family coverage. Failure to do so will result in the dependent not being covered under the Plan, and you will not be able to enroll your new dependent until the next annual enrollment period.

Two ways to request your change in coverage:

- Call the IBM Benefits Center – Provided by Fidelity at 866-937-0720. Representatives are available business days (excluding holidays recognized by the New York Stock Exchange) between 8:30 a.m. and 8:30 p.m., Eastern time.
- Log in to NetBenefits at netbenefits.com/ibm.

IBM reserves the right to require documentation supporting eligibility of your dependents such as a marriage certificate, affidavit of domestic partnership, a copy of a recent Federal Tax Return (e.g., 1040), birth certificate or adoption papers.

PAYING FOR YOUR BENEFITS

You and IBM share the cost of your benefits. Your total monthly contribution will be deducted from your paycheck on a pretax basis, before federal income taxes, Social Security taxes and most state income taxes are withheld. In the event your pay is insufficient to pay the necessary monthly contributions for all of your elections, you may be asked by the Plan Administrator to pay directly for your coverage, or your coverage may be reduced under one or more of the benefits plans. If your coverage is reduced, you may not increase or begin coverage again until the next time you are eligible to make an election.

If you increase your coverage during the year due to a qualified status change, such as adding a dependent, the new monthly charges will go into effect the first of the month following the date of the event.

If you elect "No Coverage" as your option for medical, you will receive a $30 credit each month in your paycheck, which will be treated as taxable income.

If you decline IBM coverage as a new hire or during the annual enrollment period, you may not change your election until the next annual enrollment period, unless you have a qualified status change that allows you to enroll during the year.

If you are not in active pay status — for example, on an approved leave of absence with benefits — you will need to pay your contribution monthly. Contributions will be due on the first of each calendar month with a grace period through the end of each calendar month. If payment in full is not received by the end of the grace period (end of the calendar month), you will be defaulted to "No Coverage" effective the end of the month in which the last full payment was received. It is your responsibility to ensure payment arrives on time. IBM and its contract administrators shall not be responsible for lost or misdirected mail.

Tobacco Surcharge for Medical Coverage
A $50 per month surcharge will apply for IBMers and their enrolled spouses/domestic partners who use any tobacco products. This surcharge was instituted to help offset the additional healthcare costs typically incurred by tobacco users. For purposes of this surcharge, a tobacco product is defined as "any product derived from tobacco that is intended for human consumption" (U.S. Food and Drug Administration) and includes cigarettes, cigars, pipe tobacco, roll-your-own tobacco, smokeless tobacco and e-cigarettes.

You will be asked to indicate whether you and your covered spouse/domestic partner, if applicable, have used any tobacco products within the last six months when you enroll in your medical plan coverage. You will select one of the following options for yourself and a separate option for your covered spouse/domestic partner:

- **Non-Tobacco User:** Select this option if you have not used any tobacco products since July 1.
- **Tobacco User:** Select this option if you have used any tobacco products since July 1 and do not wish to participate in your health plan administrator's tobacco cessation program.
- **Cessation Program:** Select this option if you have used any tobacco products since July 1 of the prior year but agree to complete your health plan administrator's tobacco cessation program by June 30 of the current year. (For new hires, the deadline is six months from your enrollment or by December 31, whichever occurs first.)

(Note: If your healthcare provider advises that participating in a tobacco cessation program is medically inappropriate for you due to a health factor, you should select the Cessation Program option and then contact the IBM Benefits Center – Provided by Fidelity to initiate a medical review of your situation.)

Tobacco Surcharge Details
The table below provides information about the tobacco surcharge that may be added to your contributions for medical coverage each month, depending on the option you (and your spouse/domestic partner, if applicable) select.

Option	Result	Total monthly surcharge as of January 1 of the current year
Non-Tobacco User	If you and/or your covered spouse/domestic partner indicate that you have not used any tobacco products since July 1, the tobacco surcharge(s) will not apply to your contributions for the current year's medical coverage.	No monthly surcharge will apply for each individual indicating that they have not used any tobacco products since July 1.
Tobacco User	If you and/or your spouse/domestic partner indicate that you have used any tobacco products since July 1, the tobacco surcharge(s) will apply to your contributions for the current year's medical coverage.	A $50 monthly surcharge will apply for each individual indicating that they have used any tobacco products since July 1 and do not want to participate in their health plan administrator's tobacco cessation program.

Option	Result	Total monthly surcharge as of January 1 of the current year
Cessation Program	If you and/or your covered spouse/domestic partner indicate that you have used any tobacco products since July 1, the tobacco surcharge(s) will apply to your contributions for the current year's medical coverage. However, you will have an opportunity to earn a refund of the surcharges you pay if you satisfy the requirements of **your health plan administrator's** tobacco cessation program. (Note: Although you may choose to participate in other tobacco cessation programs, you will not be eligible to receive a refund unless you complete the program offered by your IBM health plan.) To be eligible for a refund of the tobacco surcharge, you and/or your covered spouse/domestic partner must meet the health plan's tobacco cessation program requirements and then complete the certification process on http://tobaccocert.com/ibm by June 30 of the current year. (For new hires, the deadline is 6 months from your enrollment or by December 31, whichever occurs first.) If you and/or your covered spouse/domestic partner successfully complete the program's requirements and certify by this date, you will be eligible for a refund of the tobacco surcharges you paid from your effective date. If you and/or your covered spouse/domestic partner do not complete the program requirements and/or do not complete the certification process on http://tobaccocert.com/ibm by the deadline above: ▪ You will not be eligible for a refund of the tobacco surcharges you have paid in the current year. ▪ The applicable $50 per month surcharge will continue to apply for your coverage and/or your covered spouse's/domestic partner's coverage for the remainder of the current plan year.	A $50 monthly surcharge will apply for each individual indicating that they have used any tobacco products since July 1 but agree to complete their health plan administrator's tobacco cessation program. Surcharges will be discontinued — and surcharges paid to date will be refunded — if individuals complete their health plan's tobacco cessation program and certify their completion on http://tobaccocert.com/ibm by June 30 of the current year. (For new hires, the deadline is 6 months from your enrollment or by December 31, whichever occurs first.)

About the Cessation Program Option

If you select the cessation program option, you can begin the program through your health plan now. Regardless of when you begin, you must complete the program and certify your completion by June 30 of the current year in order to discontinue the monthly surcharge and receive a refund of surcharges paid to date. (For new hires, the deadline is six months from your enrollment or by December 31, whichever occurs first.) Whether you are able to stop using tobacco or not, completing the program and certification process will meet this requirement.

The cessation program will include telephonic coaching with a qualified health coach who will help you develop a 12-week cessation or maintenance plan, point you to useful resources to support your efforts and provide follow-up coaching calls. You must complete at least three total calls with the coach in order to qualify for a refund of your Tobacco Surcharge payments. These calls are typically around 30 minutes in length. There is no cost to you or your family members to participate in the program. *(Note: If you are hard of hearing and telephonic coaching is not an option for you, please contact the IBM Benefits Center for an alternative.)*

To begin the telephone coaching program, call the number for your health plan administrator's tobacco cessation program listed below. After you complete the program requirements, you will need to complete the certification process on www.tobaccocert.com/ibm by the deadline above, in order to receive a refund of the Tobacco Surcharges you have paid.

Health Plan Administrator	Tobacco Cessation Program Phone Number
IBM Plans	
Aetna (Healthy Lifestyle Coaching Program)	866-213-0153 (TTY: 877-301-5038
Anthem	877-252-8410 (TTY: 800-842-4681)
UnitedHealthcare (Optum)	800-468-1057 (TTY: 711, 800-478-1057)
Cigna Global Assignee Health Plan	800-411-2668
HMOs	
Humana (Puerto Rico)	Optum's Clinical Referral Line (CRL) at 800-445-9720 (TTY: 711, 800-445-9720)
Kaiser	866-862-4295

A Note About Taxes and Imputed Income

Tax Implications of Enrolling a Same-Sex Spouse/Domestic Partner

If you elect to cover your eligible same-sex domestic partner (or his or her children) and he or she does not qualify as a dependent under Internal Revenue Code (IRC) Section 152, you generally must pay federal income and payroll taxes (and, in most states, state taxes) on a portion of the applicable premium. This is called imputed income, and that value will be reported on your Form W-2.

If you think your domestic partner would qualify as your eligible family member, please contact the IBM Benefits Center – Provided by Fidelity or visit w3 or NetBenefits for a copy of the *Spouse and Domestic Partner Information Guide*, which contains information on eligibility, affidavits, tax implications, enrollment, etc. If you have questions about your state's tax rules, you should contact your local state tax department or your personal tax advisor.

Generally, a domestic partner is considered to be "qualified" as a "dependent relative" only if more than half of the partner's support for the year comes from the employee, and the partner resides in and is a member of the household maintained and occupied by the employee for the entire tax year and the domestic partner cannot be claimed as a dependent relative of another taxpayer. If your domestic partner does not meet the definition of a "dependent relative," he or she will be considered a "non-qualified" dependent and you will be treated as having imputed income equal to the value of his or her coverage. Imputed income will also apply to the enrolled children of your domestic partner whom you have not legally adopted. You should consult your personal tax advisor regarding tax rules and consequences.

IRS Requirements Regarding the Tax-Free Status of Dependent Children

According to federal tax laws, dependent children must meet certain tax requirements to be enrolled in IBM health coverage on a tax-free basis. Dependent children who do not meet these requirements may still be enrolled in IBM health coverage; however, the value of their coverage will be considered imputed income to you and you will be taxed accordingly.

Most dependent children who meet IBM's requirements for coverage also meet the federal income tax law requirements. Dependent children who meet IBM's requirements for coverage but do not meet the federal income tax law requirements for tax-free health coverage include children who do not have a legally recognized relationship to you, such as children of an eligible domestic partner/same-sex spouse whom you have not legally adopted.

It is your responsibility to notify the IBM Benefits Center – Provided by Fidelity if for any reason your enrolled dependent children do not meet the requirements for tax-free health coverage.

You should consult Internal Revenue Service rules or your personal tax advisor if you have questions concerning the tax dependent status of your dependent children.

LIVE WELL. LIVE BETTER. INCENTIVES AND REWARDS

The Live Well. Live Better. incentive and rewards program makes good health rewarding.

All IBMers can take steps to healthier living

Head to **CaféWell** for all the details on how IBM supports your personal health and wellbeing goals. There, you'll find a wealth of programs and resources that help you, whether you're looking to get physically active, shed a few pounds, develop a plan for retirement or improve your resilience. You'll also find links to your personal health plan administrators. Remember to invite your covered spouse/domestic partner to register.

Effective January 1, 2019, you and your covered spouse/domestic partner must complete Ready! Set! Go! to be eligible for any of the rewards program.

A **$100 device subsidy is available for all eligible IBMers** who complete Ready, Set, Go! and join a recommended a Live Well. Live Better. Rewards Program. You can use this subsidy toward a device that can help you meet your personal health and wellness goals. Plus, take advantage of quarterly wellness drawings for new program completions each quarter.

Fifty IBMers per quarter will have a chance to win 2,400 BluePoints (a $600 value), which can be redeemed for any number of valuable items. Complete recommended programs throughout the year and eligible employees gain entry to win BluePoints — IBM's digital recognition currency. BluePoints are redeemed by selecting from a broad range of merchandise, entertainment and travel options. You earn one sweeps entry per new program completion per quarter by you and your covered spouse/partner. For the final quarter (Q4), completions must be earned by December 1 of the current plan year.

Earn additional HSA contributions from IBM

If you're enrolled in a medical plan option featuring an HSA, you can earn up to $300 for individual coverage or $850 for family coverage just by completing Ready, Set, Go!. The money goes into your HSA, which means you can use it to offset health care expenses now, or save for future health care expenses.

Get started by going to **CaféWell** and completing Ready, Set, Go! – and make sure your covered spouse/domestic partner does the same so you earn the maximum reward. Ready, Set, Go! must be completed by December 1, 2019.

Here's a look at what you can earn:

		HSA Plan Options		Non-HSA Plan Options
		Individual Coverage	Family Coverage	
IBM Gives You	**IBM base contributions (prorated on a pay period basis)**	$250	$500	**Not applicable**
	HSA Jump-Start Contribution	$250	$250	
You Earn	**Ready-Set-Go contribution** program completion on *CaféWell*	$300	$850	
	Total IBM contribution potential	$800	$1600	

Remember, IBM's contributions count toward the IRS annual HSA maximums.

Note: Both employee and spouse/domestic partner, if applicable, must complete the Ready, Set, Go! program to earn the family coverage contribution. If you only have covered child dependents, you will be able to earn all of the incentives on behalf of the family.

PLAN INFORMATION

The Personal Benefits Program is a cafeteria plan within the meaning of Section 125 of the Internal Revenue Code. The program was established and effective as of April 1, 1994. The Personal Benefits Program does not provide any kind of insurance or other coverage. These coverages are provided under the various benefit plans identified earlier in this section.

Administrative Information

Administrative Information

ID CARDS

Employees enrolled in the IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees (the "Plan") under the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA, or IBM Enhanced PPO with HSA medical options will receive an ID card for medical coverage and a separate ID card for prescription drug coverage.

The ID card contains information to ensure you receive the correct negotiated rates from participating providers and facilities. Your ID card must be presented to all providers at the time of appointment or when you receive services, or to a participating pharmacy at the time of prescription drug purchase. Failure to show your ID card may cause you and IBM to lose access to any applicable discount fee arrangements.

If you and your spouse/domestic partner are each eligible for IBM benefits and one of you is enrolled as a dependent of the other, only the enrolling employee's ID card should be presented.

You may request additional ID cards for your family members directly from the health plan.

HOW TO FILE A CLAIM

Medical Claims

In-Network Medical Claims

If you receive care from an in-network provider, you generally do not have to file any claims. Your network provider will file all claims for you. Simply show your medical ID card at the time you receive services. Your network provider bills the health plan directly. Once the claim is processed by the medical plan, payment will be made directly to the network provider. Subsequently, your provider will bill you for your remaining share of the cost (e.g., coinsurance or deductible).

However, if you have other medical coverage, including Medicare, and the Plan is secondary, you must first file claims with the primary plan and then submit your claims following the out-of-network procedures described below — even if you received care from an in-network provider. For more information when you have other coverage, see "Coordinating Coverage" later in this section.

EXPLANATION OF BENEFITS (EOB)

In most cases, you will receive an Explanation of Benefits (EOB) statement from the health plan. In certain circumstances where there is no member liability, an EOB may not be produced.

If you receive EOB statements from your health plan, it is your responsibility to:

- Verify the EOB statements for medical, surgical and hospital care accurately reflect services rendered, e.g., patient, dates of service, charges and provider. (Due to negotiated or discounted rates with respect to hospital services, it may not be possible to verify dollar or rate amounts reflected on the statement.)
- Retain copies of claims and EOB statements for your records.

Out-of-Network Medical Claims with Approved Exceptions

The IBM Plan only allows payment for out-of-network claims for certain exception situations such as medical emergencies. See the full list of approved exceptions in the "*Out-of-Network Medical Coverage*" section. If your claim falls under one of the exceptions, the IBM Plan will pay benefits for these approved services as if the provider was an in-network provider, using the in-network coinsurance or copay, along

with the in-network deductible and out-of-pocket maximum that would have applied if the services were provided by an in-network provider.

You are responsible for the difference between the amount the Plan pays in benefits and the amount billed by the out-of-network provider.

Some providers will submit your claim to the medical plan administrator on your behalf, other providers may request payment in full and submit a claim to your medical plan administrator for reimbursement. In certain circumstances (i.e. high cost hospital bills), your medical plan administrator will not want you to pay for services until they have had the opportunity to negotiate a lower cost with the provider.

The provider will be reimbursed directly if authorization for assignment is indicated on the form. Generally, if benefits are not assigned, payment from the health plan administrator will be made to you.

Out-of-Area Medical Options

In certain geographies where there is not a robust network of medical providers, affected employees will be offered Out-of-Area (OOA) plan options, administered by United Healthcare which provide the same benefits coverage as described in this Summary Plan Description. The IBM EPO is not available to those who are offered OOA plan options. If this situation applies to you, it will be indicated in your enrollment materials.

With these plan options you can choose to use either in- or out-of-network providers without needing to ensure the service falls under the category of an approved exception. You will pay less out of pocket if you use provider's that participate with United Healthcare's provider network. Under the OOA plan options the IBM Plan will pay benefits for eligible services as if the provider was an in-network provider, based on the billed amount (or lower negotiated amount, if applicable) using the in-network coinsurance or copay, along with the in-network deductible and out-of-pocket maximum that would have applied if the services were provided by an in-network provider.

You are responsible for the difference between the amount the Plan pays in benefits and the amount billed by the provider.

Some providers will submit your claim to the medical plan administrator on your behalf, other providers may request payment in full and submit a claim to your medical plan administrator for reimbursement. In certain circumstances (i.e. high cost hospital bills), your medical plan administrator will not want you to pay for services until they have had the opportunity to negotiate a lower cost with the provider.

The provider will be reimbursed directly if authorization for assignment is indicated on the form. Generally, if benefits are not assigned, payment from the health plan administrator will be made to you.

You can submit out-of-area bills to the Plan as described in the "How to File Out-of-Network Medical Claims" section.

Prescription drug and mental health/substance use benefits remain subject to the in-network and out-of-network requirements, as described in the "IBM Managed Pharmacy Program" and "IBM Managed Mental Health Care Program" sections of this book.

Medical Expenses Incurred While Traveling Outside of the U.S.

Medical expenses incurred while outside of the United States are eligible for consideration as long as they are rendered in accordance with all Plan provisions. All bills or invoices should be legible and in English, if possible. If translation to English is not possible, the health plan administrator will perform the translation services when the bill is submitted. All bills should be sent to the appropriate health plan

administrator. All claims will be reimbursed in U.S. dollars. The exchange rate will be taken from a recognized publication as selected by the health plan administrator, using the rate effective on the date of discharge for inpatient hospital charges, and the date the service was rendered for all other eligible charges.

How to File Out-of-Network Medical Claims
Payment for "approved" services received out-of-network is based on the in-network rate. See the section "Out-of-Network Medical Coverage" for a description of these services.

A separate claim form is required for each family member. You will receive an Explanation of Benefits (EOB) statement from the health plan administrator detailing the services rendered. You should obtain a copy of the bill from the provider to enable accurate verification of the EOB statement. You must verify the information contained on the EOB statement received from the health plan administrator against the actual charges, dates of service, etc. If any discrepancies are found, you must advise the health plan.

Complete and sign the appropriate Plan claim form, available from the IBM Benefits Center – Provided by Fidelity or on NetBenefits. Ensure all required information, including your member ID number, is provided on the claim form and accompanying bills. Only you have the authority to sign the form certifying the validity of the claim.

The provider will be reimbursed directly if authorization for assignment is indicated on the form. Generally, if benefits are not assigned, payment from the health plan administrator will be made to you.

- Attach itemized bills and EOB statements from other insurance coverage (if applicable) to the claim form and mail to the health plan administrator at the address on the claim form. Canceled checks or cash register receipts will not be accepted. Ensure the accuracy and validity of all bills submitted for payment and make sure there is a specific treatment or diagnosis written on the bill. See the reverse side of the claim form which lists the information that must be included on the bills to avoid possible suspension or rejection of your claims.
- Advise the health plan administrator of your plan option if charges submitted for reimbursement are eligible for coverage under another employer's plan. Respond promptly to the health plan administrator's inquiries concerning the possibility of other coverage.
- If you have a written predetermination of benefits from the health plan administrator of your plan option, attach a copy to your claim form.
- In determining the appropriate reimbursement for surgical claims, the health plan administrator may request a copy of the surgeon's operative report.
- Include English translation of diagnosis, fees and treatment for services rendered outside of the U.S., if available. If the provider or facility is not able to provide a bill or claim information in English, the health plan administrator will perform translation and currency exchange services for you.
- In most instances, the claim will be processed and payment mailed within 30 days of receipt. Therefore, you should allow for mailing time plus the 30 days needed for processing before calling to follow up on the status of a claim. In some circumstances, however, due to the complexity of the claim, additional medical and technical reviews may be necessary resulting in a longer than normal processing time.

In determining whether a benefit is payable (and, if so, the benefit amount), the Plan Administrator and the health plan administrator may consult physicians, dentists and other experts selected by IBM for advice on medical necessity and other pertinent factors and may require that the patient be personally

examined by those expert(s). For determination of medical appropriateness, the health plan administrator may also contact your physician as needed.

The benefit on any assigned claim will be calculated the same way as if the claim had not been assigned; for example, in calculating the amount due, the Plan will take credit for any benefit advances or over-payments previously paid for charges by the same or any other provider. In certain circumstances where there is no member liability under the Plan option, an Explanation of Benefits will not be produced.

Deadline for Submitting Claims
Charges are considered incurred on the date the service, hospitalization, supply, surgery or other treatment is rendered. All claims must be received by the health plan administrator no later than December 31st of the year following the year in which the charges are incurred; otherwise, there will be no benefit payable. For example, if a charge is incurred on July 1, 2019, the claim must be received by December 31, 2020. You are responsible for ensuring claims are submitted on time even if the provider is filing the claim on your behalf. IBM cannot accept any responsibility for post office deliveries or claims mailed via internal mail from an IBM location.

Keep Copies for Your Records
Keep a copy of the claim form and bills for your records. You are responsible for reconciling submitted charges with claims paid as reported on the EOB statement from the health plan administrator. Copies will *not* be provided by the health plan.

Your Responsibility
It is your responsibility to follow the applicable claim filing procedures, and to advise the health plan administrator of any discounts or price adjustments made by the provider. A provider who waives or refunds deductibles, copayments and/or coinsurance amounts is entering into a discount arrangement with the employee. The benefit payment is calculated based on the amount actually charged after any discounts, rebates, waivers or refunds of copayments or deductibles. Thus, failure to notify the health plan administrator or the IBM Benefits Center – Provided by Fidelity of such a price adjustment may result in an overpayment of benefits. It therefore constitutes a serious violation of the provisions of the IBM Medical and Dental Benefits Plan and may be grounds for disciplinary action, including termination of coverage.

It is a crime to knowingly, and with intent to injure, defraud, or deceive the company, provide any fraudulent information, including filing a claim that contains any false, incomplete, or misleading information. These actions, as well as the submission of materially false information, may result in rescinding your coverage under the IBM health plan(s), retroactive to the date of the fraudulent act, and you may be subject to prosecution and punishment under state and/or federal law. The IBM health plan(s) would terminate coverage of a participant or beneficiary for a reason such as fraud.

Hospital/Facility Billing
Inpatient and outpatient hospital claims cannot be reimbursed directly to you. Negotiated prices, which create savings for you and IBM, will only take effect if the health plan administrator pays hospitals directly for covered charges. Present your identification card at the time services are rendered; do not pay up front. Hospital inquiries should be referred directly to the health plan administrator. If you pay a hospital for outpatient and inpatient services, the health plan administrator will reimburse the hospital for the eligible covered charges and you will have to obtain a refund directly from the hospital.

Note: IBM recommends that you do not pay the hospital any amounts other than copayments until you receive your EOB. You may not receive the discounted rate if you pay the hospital directly.

- *Inpatient Charges:* Hospitals will send a bill for charges directly to the health plan administrator and then bill you for any balance remaining after benefits have been paid to the facility by the health plan administrator.
- *Outpatient Charges:* In most cases, facilities will send a bill for eligible charges to the health plan administrator and then bill you for any balance remaining after benefits have been paid to the facility. If hospitals request a payment at the time of service, they may request the coinsurance payment (the amount not reimbursable by the Plan) and not the total charges. It is the hospital's own particular billing practices which determine whether payment will be required at the time of service or at a later date. In certain circumstances, such as a mother and newborn child, billing may be separate.

Hospital Bill Reconciliation

As a result of applicable state laws and/or contracts between some facilities and the health plan administrator, actual payments that a facility will accept as payment in full may vary from the facility's nominal charges. For example, in some areas of the country, payments to hospitals for inpatient stays are based on a patient's medical diagnosis rather than on the fee-for-service and per-diem charges which appear on the hospital's invoices. This payment methodology is referred to as a DRG (Diagnosis Related Group) methodology. Under a DRG system, a hospital receives a predetermined amount for the care of a patient with a specific diagnosis. Length of stay and non-operative services rendered to the patient while in the hospital do not affect the payment amount. A hospital's bill, nevertheless, will show charges at the hospital's standard rates on a fee-for-service basis, even if the DRG methodology actually applies instead. Similarly, a negotiated or discounted rate may apply at times, but might not be reflected on the billing you receive from the hospital.

In these situations, the benefit which the Plan pays may equal a different percent of the total amount the facility accepts as payment in full than that specified under the IBM Plan. In any case, the amount of your coinsurance will never be more that it would have been had the hospital required payment for the services at its full nominal rates.

Any questions regarding specific charges and reimbursements should be directed to the health plan administrator.

Managed Mental Health Care Program Claims

Claims processing is handled by Optum by United Behavioral Health, the administrator for the Managed Mental Health Care Program. Optum will pay eligible mental health/substance use claims.

In-Network Managed Mental Health Care Program Claims

Network providers submit claims directly to Optum for their treatment services and are paid directly by Optum for covered services under the Plan. The provider will bill you for any applicable deductibles, coinsurance or copayments.

For claims paid for the IBM PPO, IBM PPO Plus, IBM PPO with HSA, IBM Enhanced PPO with HSA and IBM EPO options, Optum will send you an Explanation of Benefits (EOB) statement. Verify it for accuracy and retain it for your records. You must bring any discrepancies to the attention of Optum's Member Services Department.

Out-of-Network Managed Mental Health Care Program Claims

If you use an eligible practitioner or eligible program/facility not in the Optum network or if you use a network practitioner and you do not precertify outpatient care, the provider will bill you for the charges.

It is your responsibility to submit out-of-network claim forms to Optum for reimbursement of these charges. You must submit claims for out-of-network reimbursement directly to Optum. All out-of-network claims are subject to medical necessity review by Optum upon submission.

Out-of-network claims may be submitted online at www.liveandworkwell.com, or mail completed out-of-network claims, together with any required paperwork, to:

Optum
P.O. Box 30755
Salt Lake City, UT 84130-0755

Out-of-Network Facilities and Hospitals
If you use an out-of-network facility, the facility may submit a bill to Optum. You will then receive an Explanation of Benefits (EOB) statement from Optum (and a bill from the facility for any ineligible amount Optum does not pay to the facility). However, an out-of-network facility may bill you directly. You should not pay the hospital bill until the hospital has submitted claims to Optum and the amount for which you are financially responsible has been determined. Remember that out-of-network, non-urgent, residential and day rehabilitation care outside your state of residence or immediate bordering state is not covered.

If Your IBM Plan Is Secondary
If your IBM benefit plan provides secondary coverage, you are required to submit an EOB statement from your primary carrier with every claim submitted. All claims are subject to a medical necessity review at Optum's discretion.

International Claims
There are generally no participating providers or facilities overseas, therefore no precertification is required for employees and their eligible dependents who receive care overseas. Claims will be reimbursed, subject to Plan limitations, at the in-network level for medically necessary services rendered by an eligible provider and/or eligible facility.

To file an international claim, submit a Mental Health Care Program Claim Form to Optum along with the complete supporting provider documentation and itemized bills in English. All claims will be paid in U.S. dollars. The exchange rate will be taken from a recognized exchange rate publication, as selected by Optum, using the rate effective on the date of discharge for inpatient hospital charges and the date the service was rendered for all other eligible charges.

Dental Claims
Generally, your network dentist will submit your claim directly to MetLife and you will not need to obtain a claim form.

If you do need to file a claim for dental treatment, follow these steps:

- Obtain an IBM MetLife Dental Claim Form from www.metlife.com/mybenefits, w3 or by calling MetLife at 800-872-6963.
- Bring the claim form with you to the dental appointment.
- Complete and sign the IBM MetLife Dental Claim Form at the time services are provided. The IBM employee must sign the claim form certifying the validity of the claim. Claims will only be processed for covered eligible family members who are listed on your benefits on file with IBM.
- Ask your dentist to complete the "Dentist Section" on the claim form and return it to MetLife at the address on the form. You may also submit the claim form yourself with the appropriate supporting documentation (e.g., itemized bill).

- Your dentist may submit an electronic claim only if he or she maintains the appropriate "signature on file."
- Payment will be made to you or your dentist as indicated on the claim form.

Claims for services must be received at the MetLife claim office no later than December 31st of the year following the year charges are incurred.

Note that if you and your spouse/domestic partner are eligible for IBM dental coverage each in your own right and one of you is enrolled as a dependent of the other, all claims must be filed by the Plan participant only.

How to File a Claim for Orthodontic Treatment
When submitting a claim for comprehensive orthodontic treatment, it is only necessary to submit the claim once, at the beginning of the active treatment period. However, MetLife may request additional information periodically to verify that you or your dependent is still receiving active treatment. Payment will be made to you or the dentist, as indicated on the claim form. You must remain enrolled in the Dental Plus option while undergoing orthodontic treatment to continue to be eligible for the benefit.

Flexible Spending Accounts (FSA) Claims:
Health Care Spending Account (HCSA) and Dependent Care Spending Account (DCSA)
To receive reimbursement from your account for eligible non-reimbursed health care expenses, (HCSA) or eligible child care expenses (DCSA) you should access your HCSA account on Acclaris by going to www.acclarisonline.com. Once on the Acclaris website you can click on 'Enter New Claim' and fill in the required fields. Once you have completed the required fields you can upload your supporting documentation for your expense.

Examples of supporting documentation would be:

- *Explanation of Benefits, if applicable.* If an expense is of a type covered by a company's benefits plan or another source, you must attach a copy of the Explanation of Benefits (EOB) statement or other evidence indicating the amount of reimbursement you have already received for the claim.
- *Evidence of Expense.* If an eligible expense is not of a type covered by a benefit plan or any other source, you must provide acceptable evidence of your expense, such as a bill from the provider. Generally, cancelled checks and cash register "receipts" are not acceptable evidence of your expense. However, a receipt indicating the amount paid for eligible prescription drugs is acceptable, as long as the prescription medication name is printed on the receipt. The bill or receipt must contain the following information
  - Name of employee or dependent for whom the service/product was provided
  - Date the expense was incurred (i.e., date the service was rendered or product was supplied)
  - Provider's name and address
  - Type of service/name of product provided and
  - Amount of expense.
- *Provider Certification, for certain expenses.* For example, for the expenses listed below, you may be required to submit certification from your provider indicating the specific medical disorder, the specific treatment needed, duration of treatment and how this treatment will alleviate the medical condition. While this list includes most of the expenses for which a doctor's certification may be required, it is not all inclusive. To determine whether you may be required to submit such a certification, contact Acclaris. Examples of expenses that require certification from your provider are
  - Therapy (speech, physical, massage, etc.)

- Durable medical equipment
- Allergy relief equipment
- Capital expenses
- Special school or tutor for a dependent with a learning disability and
- Weight loss programs (requires doctor's statement indicating a diagnosis of obesity, diabetes or hypertension).

If your claim is approved, you will receive reimbursement directly from Acclaris. Make sure you sign up for direct deposit on the Acclaris website to receive your reimbursement faster and having it directly deposited into your checking or savings account. If you do not sign up for direct deposit, there is a minimum reimbursement amount of $25. Please note: a check is not mailed until you accumulate $25 or more in reimbursements. Reimbursements are made daily. In most cases, claims will be processed within 10 business days from receipt. Account and claim payment information is available on the Acclaris web site or by calling Acclaris.

HCSA Claims Submission Deadline
A run-out period for claims submission is provided through June 30th immediately following the close of the plan year to allow time for any outstanding claims incurred in the prior plan year or any grace period that may apply to be sent to Acclaris.

Claims postmarked after June 30th for the immediately preceding plan year, including claims for reimbursement of eligible expenses incurred during any grace period related to that plan year, will be ineligible for reimbursement. However, if you have missed the deadline for claims for the preceding plan year, claims incurred during any grace period can be submitted against your HCSA for the plan year in which the grace period occurs if you are participating in the Plan for that plan year. For information about grace periods, see "Health Care Spending Account Grace Period" in the Health Care Spending Account section.

DCSA Claims Submission Deadline
A run-out period from January 1st through June 30th of the following year is provided to allow time for any outstanding claims from the previous year to be received and processed. Claims postmarked after June 30th for expenses incurred in the preceding plan year will be ineligible for reimbursement.
All questions regarding claim payments or account balances should be directed to Acclaris.

CHANGING COVERAGE DUE TO A QUALIFIED STATUS CHANGE

During the year, you may be eligible to make certain changes to your benefits options if you experience a qualified status change to your family, employment or coverage status. These types of changes are limited by the IRS under Section 125 of the Internal Revenue Code. (However, please note the types of circumstances for which the Personal Benefits Program allows a change, and the types of changes allowed, are not necessarily all those that the IRS would permit.)

Examples of qualified status changes for which the Personal Benefits Program allows a change are:

- Marriage or divorce
- Entering or terminating a domestic partnership
- Birth or adoption of a child
- Death of your spouse/domestic partner or dependent
- You or your spouse/domestic partner taking an unpaid leave of absence
- You or your dependent gains or loses other coverage

You Must Request Your Change within 60 Days

If you have a qualified status change during the plan year, you must call the IBM Benefits Center – Provided by Fidelity or log in to NetBenefits to make eligible changes to your coverage within 60 days of the date of the qualified status change. Otherwise, you will not be able to make changes until the next annual enrollment period and your changes will not take effect until the next plan year. If you make your change within 60 days of the event, Qualified Status Changes related to a child's birth will be retroactive to the child's birthdate. Other Plan changes are generally effective on the first of the month following your request. If you are adding an eligible family member, keep in mind that you may be required to submit documentation to support the eligibility of your new dependent.

Any requested change in coverage must be consistent with the qualified status change. For example, if you are single and get married, or become eligible for domestic partner coverage, you can add coverage for your new spouse/domestic partner by changing from "Self only" to "Self plus spouse/domestic partner."

Changing a Family Member's Eligibility Status

You must call the IBM Benefits Center – Provided by Fidelity or log in to NetBenefits within 60 days of any event that causes an enrolled family member to become ineligible for coverage under the provisions of the Plan. Note the individual losing coverage may be eligible to elect continuation coverage under the Transitional Medical Program.

Qualified Status Changes At-A-Glance

The following chart shows some of the more common events for which you can make changes in coverage.

Event	Medical/Dental/Vision	HCSA/DCSA
Gain a Dependent ▪ Birth ▪ Adoption ▪ Stepchild ▪ Change in custody ▪ Marriage ▪ Domestic partnership	May increase coverage category or change plan options.	May begin or increase contribution amount.
Lose a Dependent ▪ Divorce ▪ Death ▪ Dependent loses eligibility ▪ Termination of domestic partnership	May decrease coverage category. May not change options (see medical and dental "No Coverage" options for exceptions).	May cancel or decrease contribution amount.
Spouse/Domestic Partner/Same-Sex Spouse Loses Health and Welfare Coverage Elsewhere	May increase coverage category or elect medical and dental coverage if you previously waived coverage and were covered by your spouse or domestic partner. May also change Plan option.	May begin or increase contribution amount.
Move Out of the HMO or IBM EPO Service Area	May change medical or dental option. May not change coverage category.	No changes allowed.

Note: Due to IRS regulations, HCSA/DCSA cannot reimburse expenses for domestic partners who do not meet the applicable tax law definition of "dependent." Also, a domestic partner cannot be treated as "married" for purposes of determining the employee's maximum allowable contribution to the DCSA.

Events that Do Not Count as Qualified Status Changes

Only events that are considered qualified status changes permit you to make certain changes to your benefits during the year. The following events do not qualify as qualified status changes:

- A mistake in enrollment, such as selection of the wrong plan option
- Attaining an annual or lifetime maximum during the plan year
- Your physician or hospital does not participate or stops participating in the Plan's network

If You Change Medical Options During the Plan Year

If you experience a qualified status change and change your medical options during the year, amounts accrued toward satisfying your prior option's annual deductibles and out-of-pocket maximums for that year will be applied toward satisfying the new option's annual deductibles and out-of-pocket maximums — but only up to the amounts of the deductible and out-of-pocket maximum of the plan in which you have newly enrolled. Excess amounts will not be reimbursed.

You must notify the health plan for your new option directly to receive any applicable credits toward deductible and out-of-pocket maximum. You will be asked to provide a copy of the latest Explanation of Benefits (EOB) statement from your prior health plan. (If you and your spouse are both eligible for IBM coverage, and as a result of a qualified status change you change your enrollment from being primary to being a dependent of your spouse, deductibles and out-of-pocket maximums are not transferable.) There will be no carryover of credits against deductibles from one plan year to another.

If you leave a medical plan option which does not have a deductible and change to a medical plan option that has a deductible, you must meet the new plan's deductible before you become eligible to receive benefits. Alternatively, if you leave a medical plan option where you have accumulated amounts towards or have met the deductible and change to a plan that does not have a deductible, there is no deductible transfer or credit.

For more details about qualified status changes, call the IBM Benefits Center.

COORDINATING COVERAGE

IBM Couples

If you and your spouse/domestic partner both work for IBM and are eligible to participate in the Personal Benefits Program to elect medical, dental and vision coverage through IBM, you must choose each plan year whether to enroll for individual coverage separately or as an eligible family member under the other's coverage. You must each separately elect to participate in the Health Incentives to be eligible to receive them.

Because of the special tax consequences for same-sex spouse/domestic partner benefits, you should consider the financial effects of your enrollment decisions. Please see the *Spouse and domestic Partner Information Guide,* available on w3 or NetBenefits.

As an IBM couple, you can enroll for coverage in one of two ways:

- You and your spouse/domestic partner can enroll individually, and each of you can choose your own options. However, each of you will pay your own contributions and will need to satisfy separate deductibles and out-of-pocket maximums based on the options you choose. Eligible family members may be covered by you or your spouse/domestic partner. An employee can enroll:
  - All dependent children together under one employee, or
  - Split the children between each employee parent.

  Enrollment does not have to be the same for medical, dental and vision — different combinations of enrollment can be used; however, the children can never be enrolled twice.

- One of you can enroll for coverage as a plan participant and cover the other as a family member, along with any eligible children. The IBM spouse/domestic partner who is covered as a family member would elect no coverage.

No Duplicate IBM Coverage

A person who has IBM medical, dental or vision coverage in one capacity will not have further IBM coverage under the same or any other IBM-sponsored medical, dental or vision benefits Plan in any other capacity. For example:

- A person covered as an IBM employee will not also be covered as a retired IBM employee.
- A person covered as the spouse/domestic partner of an IBM employee will not also be covered as the surviving spouse or as the surviving domestic partner of a deceased IBM employee.
- A person covered as an eligible dependent child of one IBM parent will not also be covered as an eligible dependent child of the other IBM parent for the same Plan option.
- A person who has coverage as an eligible dependent child of a parent will not also be covered as an eligible dependent child of a stepparent, or as an eligible surviving child of a deceased parent.

As explained previously in "IBM Couples," special rules apply in the case of spouses/domestic partners who each have individual IBM coverage in their own right (that is, on account of being an active, inactive or retired IBM employee, or an MDIP or LTD benefits recipient). Neither will have secondary IBM coverage as the spouse/domestic partner of the other. Likewise, there is no duplication of Plan maximums. Charges will only be eligible under and applied to the primary employee's maximums. If you have a qualified status change and change your enrollment from being primary to being a dependent of your spouse/domestic partner, deductibles and out-of-pocket maximums do not transfer even if you stay in the same Plan option.

If You or a Family Member Have Other Coverage

If you or an eligible family member have other group health plan coverage in addition to IBM coverage, IBM medical and dental benefits will be coordinated with the other coverage to avoid duplication of payment. When the IBM Plan's responsibility for benefits is secondary to that of the other coverage, the IBM Plan will not pay a benefit for an eligible expense until the other coverage has paid, and the IBM benefit amount which would normally apply will be reduced by the amount the other coverage paid.

It is your responsibility to keep your other coverage information current by promptly reporting changes to the health plan you are enrolled in. It is your responsibility to provide updates to your other health coverage information. If you do not respond to a request(s) by your health plan to update your other coverage information, your claims may be denied until the plan receives your information.

Some providers give a discount when the IBM Plan has primary responsibility for payment. If you use one of these providers, the IBM benefit will be calculated using the discount price, even if in your case the IBM Plan was not primary and you therefore did not receive the discount.

Even when IBM coverage is secondary, the IBM Plan will not pay benefits for ineligible expenses, such as the difference between private room charges and semi-private room charges. Likewise, the IBM Plan will not waive deductibles or out-of-pocket copayment requirements, even in situations where IBM coverage is secondary. For more information, see "Coordinating Benefits with Another Health Plan" in this section.

Coverage for Medicare-Eligible Dependents

As an active employee, the IBM medical plan options provide primary coverage for you and any of your covered dependents, even if anyone is eligible for Medicare. Therefore, if you cover a Medicare-eligible dependent, the IBM Plan will provide your dependent's primary coverage and Medicare will provide secondary coverage.

IBM coverage is primary for the Medicare-eligible domestic partner or Medicare-eligible same gender spouse of an active employee. Please be aware it is important for the Medicare-eligible domestic partner or Medicare-eligible same sex spouse to apply for enrollment in Medicare in a timely manner (when first eligible for Medicare); otherwise their Medicare coverage may be delayed, and they may incur a surcharge on their Medicare monthly premiums as a penalty for late enrollment.

Note: There are a few rare circumstances when Medicare will pay primary over your medical coverage as an active employee, such if you have End Stage Renal Disease (ESRD). Refer to the government regulations on who pays primary found on Medicare.gov.

Coverage for prescription drugs under all options under the IBM medical plan for active employees meets Medicare's "creditable coverage" standard, which means IBM's coverage, on average for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage. Medicare-eligible individuals may be enrolled in IBM medical coverage that provides coverage for prescription drugs or a Medicare prescription plan, but not both. Do not enroll your dependent in coverage under the IBM medical plan for active employees if they are enrolled in Medicare Part D.

Coordinating Benefits with Another Health Plan

If you or your eligible family members are covered by the IBM Medical, Dental or Vision Plans and by certain other types of coverage, the IBM Plans will coordinate your benefits with other health coverage. The plan that pays first depends on which plan is primary and which plan is secondary. The primary plan pays first. Generally, IBM's Plans are primary for a covered active employee and secondary for a spouse who also is covered by his or her own employer's plan. A plan without a Coordination of Benefits (COB) provision pays before a plan that has a COB provision.

The primary plan for your covered eligible dependent children is determined by the birthday rule — the plan of the parent whose birthday occurs first during the calendar year pays first. For example, if you and your spouse are covered by different group plans and you each cover your dependent children and your birthday is in June and your spouse's birthday is in October, your plan is the primary plan for your children and your spouse's plan is the secondary plan. If both parents have the same birthday (based on month and day only), primary coverage is from the plan of the parent who has had coverage longer. See below for special rules if the child's parents are divorced or legally separated.

When filing claims, you should always file the claim with the primary plan first. If you are unsure which plan is primary and which is secondary, contact the IBM Benefits Center – Provided by Fidelity.

IBM's Plan Is Primary to Another Employer's Plan When the Patient Has

IBM Coverage as	And, the Other Coverage as
▪ An active or inactive employee, or an MDIP or LTD benefits recipient. ▪ An active employee. ▪ The eligible dependent child of his or her parent with the earlier birthday (based on month and day only). ▪ The spouse/domestic partner or eligible dependent child of an active IBM employee.	▪ The eligible spouse/domestic partner or surviving spouse/surviving domestic partner of an employee of another employer. ▪ A retired employee of another employer. ▪ The eligible dependent child of his or her parent with the later birthday (based on month and day only). ▪ The spouse/domestic partner or eligible dependent child of a retired employee of another employer.

IBM's Plan Is Secondary to Another Employer's Plan When the Patient Has

IBM Coverage as	And, the Other Coverage as
▪ The spouse/domestic partner of an active or inactive employee, or of an MDIP or LTD benefits recipient. ▪ The eligible dependent child of his or her parent with the later birthday (based on month and day only). ▪ An inactive employee or an MDIP or LTD benefits recipient. ▪ The spouse/domestic partner or eligible dependent child of an inactive employee, MDIP or LTD benefits recipient.	▪ An employee or retiree of another employer. ▪ The eligible dependent child of his or her parent with the earlier birthday (based on month and day only). ▪ An active employee of another employer. ▪ The spouse/domestic partner or eligible dependent child of an active employee of another employer.

Coordinating Benefits in the Situation of Divorce or Separation

If a child's natural parents are legally separated or divorced, and the child is covered under one employer's plan as the child of one natural parent and under another employer's plan as the child of the other natural parent or stepparent, (or, if both parents have coverage under the IBM Plan), the order of responsibility for payment of benefits will be determined in accordance with the following rules:

- A court decree stating that the IBM Plan or the IBM employee's coverage is primary will not be controlling.
- If a court decree specifically designates one of the child's natural parents as having financial responsibility for the child, then the plan of the natural parent having financial responsibility for the child under the court decree is primary over the other natural parent's plan.
- If the court decree does not specifically designate one parent as having financial responsibility, or if the court decree provides for any form of joint or shared financial responsibility, then the plan of the natural parent with whom the child resides for the majority of the calendar year is primary. If custody is joint, and the child is not determined to reside with one parent for the majority of the calendar year, the plan of the natural parent with the earlier birthday (month and day only) is primary.
- The plan of a natural parent with custody of the child normally is primary over the plan of a stepparent married to that natural parent.
- The plan of a natural parent who is neither specifically designated in the court order as having financial responsibility nor has custody of the child, normally has last responsibility for benefits.

"Financial responsibility" means that the parent having financial responsibility for the child provides more than half of the child's financial support each year.

The IBM Plans Do Not Coordinate When Benefits Are Provided from Other Sources

- Benefits will not be payable when charges for treatment of an illness or injury are compensable under a workers' compensation law.
- Benefits will not be payable when any of the charges for treatment of an illness or injury are provided for under federal, state or municipal laws or regulations.
- No benefits are payable when any of the charges for treatment of an illness or injury are provided in hospitals of the federal, state or municipal governments unless the amount charged would be payable by the individual irrespective of the existence of the IBM Medical and Dental Benefits Plan.

- If a child becomes a ward of the state, the child is no longer an eligible dependent, and benefits are not payable by the IBM Medical and Dental Benefits Plan.
- If payments are received from such other sources as described above after payment of benefits from the IBM Plan, IBM will expect reimbursement when the payment by the other source is made. Please refer to "Recovery Provisions."

IBM MEDICAL COVERAGE AND MEDICAID

Effect of Medicaid on IBM Coverage

The IBM Medical and Dental Benefits Plan will enroll participants and eligible family members, and determine and pay benefits, without taking into account their receipt of, or eligibility for, medical assistance under a federally-approved state Medicaid program. However, the IBM Plan will honor:

- Any assignment of rights which was made by or on behalf of a participant or eligible family member, if the assignment was legally required by a federally approved state Medicaid program.
- Any rights which a state has under state law to be reimbursed from benefits legally owed by the Plan for items or services for a participant or eligible family member, to the extent the state's Medicaid program has paid for those items or services.

Medicaid/State Child Health Insurance Plans (CHIP)

Eligible employees and their eligible dependents are allowed to enroll in the IBM health benefits plan mid-year if:

- Their coverage is lost under their respective state Medicaid or CHIP; or
- They become eligible for premium assistance under their respective state Medicaid or CHIP.

If you are not already enrolled in the IBM health benefits plan when one of the above events occurs, you will be able to enroll yourself and your eligible dependent(s) within 60 days of the date of the event.

Coverage will be effective retroactive to the date of the loss of Medicaid or CHIP coverage or the date you become eligible for premium assistance under Medicaid or CHIP, as applicable.

Enrollment requests received later than 60 days after one of the above events will not be accepted. However, you will have an opportunity to enroll during the next annual enrollment period.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myarhipp.com/ Phone: 855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/hipp Phone: 877-357-3268
FLORIDA – Medicaid	**GEORGIA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 877-357-3268	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA – Medicaid	**IOWA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 800-403-0864	Website: http://dhs.iowa.gov/hawk-i Phone: 800-257-8563
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 785-296-3512	Website: https://chfs.ky.gov Phone: 800-635-2570
LOUISIANA – Medicaid	**MAINE – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888-695-2447	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800-862-4840	Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800-657-3739 or 651-431-2670

MISSOURI – Medicaid	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 800-852-3345, ext 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 800-701-0710
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800-541-2831	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844-854-4825	Website: http://www.insureoklahoma.org Phone: 888-365-3742
OREGON – Medicaid and CHIP	**PENNSYLVANIA – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 800-699-9075	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 800-692-7462
RHODE ISLAND – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347	Website: https://www.scdhhs.gov Phone: 888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 888-828-0059	Website: http://gethipptexas.com/ Phone: 800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 855-242-8282	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://mywvhipp.com/ Toll-free phone: 855-MyWVHIPP (855-699-8447)	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531	

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

COORDINATING IBM MEDICAL COVERAGE WITH MEDICARE

If you or a family member covered under the IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees become eligible for Medicare coverage (due to attainment of age 65 or disability), you, or your family member, are not required to enroll in Medicare due to your employment status. However, if you or your dependent enrolls in Medicare, then the IBM *Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees* will be primary to Medicare and Medicare will pay secondary. When you leave IBM, you will be required to enroll in Medicare unless you, or your spouse, are employed somewhere else and enrolled in another employer's group health plan.

Note: There are a few rare circumstances when Medicare will pay primary over your medical coverage as an active employee, such as if you have End Stage Renal Disease (ESRD). Refer to the government regulations on who pays primary found on Medicare.gov.

If you are not employed, and you are Medicare eligible, and eligible for retiree medical benefits through IBM, you and your Medicare-eligible dependents may be eligible to enroll in medical or prescription drug coverage through the Via Benefits Medicare marketplace and your non-Medicare eligible dependents may be eligible to enroll in coverage through the *IBM Benefits Plan for Retired Employees.*

If you are not employed, and are not Medicare eligible but have a Medicare eligible spouse or domestic partner, their Medicare coverage will be primary over IBM coverage through *The IBM Benefits Plan for Retired Employees. The IBM Benefits Plan for Retired Employees* does not coordinate with Medicare Part D plans so your eligible family members should not enroll in both an IBM Plan and a Medicare Part D prescription drug plan.

Under federal law, where an individual's Medicare coverage would be secondary to that of IBM's Plan the individual can opt to receive Medicare as primary coverage by specifically rejecting IBM coverage. However, if the individual chooses to have Medicare as primary coverage, no secondary or supplementary coverage will be available for the individual through IBM under any medical plan.

The federal government has indicated that an employee is considered to be in current employment status if the employee is working for the employer or is receiving payments from the employer which are subject to FICA tax.

Note: The Medicare program and laws are subject to change. Also, the Medicare laws are quite complex and subject to government interpretation. You should consult your local Social Security office for more detailed or current information about Medicare.

Note: The Balanced Budget Act of 1997 allows physicians or practitioners to sign "private contracts" with Medicare beneficiaries for which no claim can be submitted to Medicare by either the provider or beneficiary. Services provided under "private contracts" are not covered by Medicare.

If eligible individuals enroll in Medicare Part B, and choose to enter into a "private contract" arrangement with one or more providers, they have, in effect, "opted out" of Medicare for the services provided by these providers. No benefits will be paid by the IBM Plan for services rendered by providers with whom such "private contracts" have been made.

Enrollment in Medicare

If you are, or your spouse is, actively employed, and have medical coverage through your active employment, you do not have to enroll in Medicare until such time as employment ends.

The *Medicare & You* guide and other information about Medicare are available online at Medicare.gov or from your local Social Security office. It is important not to miss a deadline for applying for enrollment in Medicare. Enrollment in Medicare Parts A and B occurs automatically for some people who have been receiving monthly income benefits from Social Security before age 65. Anyone else will not be enrolled in Medicare unless he or she applies. If enrollment is not automatic in your case, *it is important to apply for enrollment in a timely manner; otherwise your coverage may be delayed, and you may incur a surcharge on your Medicare monthly premiums as a penalty for late enrollment.*

- If you decide to not enroll in Medicare Part B when you are first eligible, when you do enroll, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B but did not sign up for it.
- If you decide to not join a Medicare drug plan when you're first eligible, and you don't have other creditable prescription drug coverage (and you don't get Extra Help), you'll likely pay a late enrollment penalty if you join a Medicare Part D plan later.

Note: The Medicare program and laws are subject to change. Also, the Medicare laws are quite complex and subject to government interpretation. You should consult your local Social Security office for more detailed or current information about Medicare.

Note: If you and/or your eligible dependents become eligible for Medicare due to disability, you must enroll in Medicare and contact the IBM Benefits Center – Provided by Fidelity directly to report the Medicare Parts A and B effective dates.

Medicare Part D Creditable Coverage

All of the active IBM Plan options provide creditable coverage under Medicare Part D. This means IBM has determined the IBM Plan options are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. This is important because if you or your Medicare-eligible dependents do not get Medicare prescription drug coverage (or creditable coverage), when you are eligible for Medicare, you may have to pay a higher premium for Medicare Part D prescription drug coverage if you join later. You will have to pay that higher premium as long as you have Medicare Part D prescription drug coverage.

The IBM Plan options are reviewed annually to determine if they provide creditable coverage. The results are listed in the *IBM Notice of Creditable Coverage*, which can be found on w3 "Legal notices/formal HR documents."

OVERPAYMENT OF BENEFITS

The claims administrator will determine in its sole discretion whether an overpayment has been made to a participant or on a participant's behalf. An overpayment described in this section may occur for any reason, including because of fraud against the plan or because of a mistake made by the claims administrator.

If a benefit payment is made by the Plan, to you, or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce, by the amount of the overpayment, any future benefit payment made to, or on behalf of, a Participant in the Plan.

IF YOU RECEIVE AN OVERPAYMENT OF BENEFITS

It is your responsibility to reimburse the Plan if you and/or your covered family members receive an IBM benefit payment to which you (or they) are not entitled — for example, because of an administrative error, dental or health plan processing error, Workers' Compensation payments, payment from another benefit plan, Medicare or other source primary over the IBM coverage (e.g., automobile insurance or proceeds from litigation). If such an overpayment occurs for any reason, you are obligated to reimburse the IBM Plan for the amount of the overpayment.

Failure to reimburse IBM may result in any or all of the following actions: Collection measures by IBM and/or a debt collector, application of all or any portion of an overpayment toward satisfaction of other claims for benefits, loss of eligibility under the IBM Plans, termination of IBM employment, civil litigation and criminal prosecution. See "Recovery Provisions" below for more information.

If a third party receives an overpayment of benefits

If the claims administrator, in its discretion, paid benefits on behalf of a participant directly to a provider, the claims administrator may recover an overpayment that the Plan makes to such provider on such participant's behalf by reducing future payments to the provider by the amount of the overpayment. These future payments may be benefits payable to such participant, to other participants in this Plan, or to participants in other health plans that are administered by the claims administrator. If these future payments are benefits payable to participants under a health plan other than this Plan, the claims administrator will credit this Plan with the amount of the future payments that such other health plan makes. However, the claims administrator will not offset future payments that it would otherwise make to a provider on behalf of a participant in another plan by an overpayment the claims administrator has made to the provider under the Plan unless the provider has affirmatively consented in writing to repay overpayments through offsets and agreed not to attempt to recover such offsets from affected participants through balance billing or otherwise.

Conversely, if the claims administrator determines in its sole discretion that a self-insured health plan that the claims administrator administers, other than this Plan, has overpaid a provider, the claims administrator has the right to reduce, by the amount of such overpayment, any future payments that the claims administrator would otherwise make to such provider on behalf of a participant in this Plan. In this situation, the claims administrator credits the other self-insured health plan that previously overpaid the provider with the amount of the future payments that this Plan makes on behalf of participants in this Plan. However, the claims administrator will not offset future payments that it would otherwise make to a provider on behalf of a participant in the Plan by an overpayment the claims administrator has made to the provider under another plan unless the provider has affirmatively consented in writing to repay

overpayments through offsets and agreed not to attempt to recover such offsets from affected participants through balance billing or otherwise.

THIS RIGHT DOES NOT AFFECT ANY OTHER RIGHT OF RECOVERY THE PLAN MAY HAVE WITH RESPECT TO OVERPAYMENTS

RECOVERY PROVISIONS

Benefits under the IBM Plan are coordinated not only with other group health benefit plans but also with other sources of payment. "Other sources of payment" include, but are not limited to, automobile insurance, awards, judgments or settlements in connection with tort claims, malpractice claims, product liability claims or contract claims, regardless of whether any portion of the award, judgment or settlement is specifically allocated or attributed to health or medical care expenses. IBM coverage is secondary, to the fullest legally-permissible extent, to such other sources of payment. If you or your covered dependent have a claim for benefits under an auto insurance policy or health insurance policy, you or the covered dependent should submit a claim under that policy before submitting a claim for IBM benefits.

If payment(s) from the other source(s) plus payment(s) by the IBM Plan exceed 100% of the medical expense incurred, the excess is an overpayment of IBM benefits and is subject to the provisions of this section. You or the covered dependent or the legal representatives, estate or heirs of you or the covered dependent, shall promptly reimburse to the IBM Plan from any settlement, verdict or insurance proceeds received by you or the covered dependent (or by their legal representatives, estate or heirs), the amount of such overpayment.

In order to secure the rights of the Plan under this section, you or the covered dependent hereby: (1) grants to the Plan a first priority equity lien against the proceeds of any such settlement, verdict or other amounts received by you or the covered dependent; (2) assigns to the Plan any benefits you or the covered dependent may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement; and (3) holds any payment received from a third party arising from an illness, injury, or condition, whether recovered through a settlement, judgment, or otherwise, in a constructive trust for the benefit of the Plan, until the Plan releases its rights to the funds. You or the covered dependent (or his or her legal representatives, heirs or estate) will sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to make such assignment of benefits.

The Plan is entitled to full reimbursement of its overpayment on a first-dollar basis from any third party payments (before subtraction of attorneys' fees and other expenses), even if payment to the Plan results in a recovery to you or the covered dependent that is insufficient to make him whole (i.e., the "make whole" and "common fund" doctrines do not apply). In addition, the Plan is entitled to full recovery regardless of whether any liability for the payment is admitted by the third party and regardless of whether the settlement or judgment received by you or the covered dependent identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

You or the covered dependent will cooperate with the Plan and its agents, and will sign and deliver any documents the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information and take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the amount of the overpayment described previously. You or the covered dependent will not take any action that prejudices the Plan's right of reimbursement. The Plan will be responsible for only those legal fees and expenses to which it agrees in writing. If the Plan must institute legal action against you or the covered dependent to recover the overpayment, you or the covered dependent will be liable for all costs of collection, including reasonable attorney's fees.

When another party is, or may be considered, liable for your or the covered dependent's injury, sickness or other condition (including insurance carriers who are so liable) for which the Plan has made an overpayment as described above, the Plan is subrogated to all of the rights of you or the covered dependent against any party liable for your or the covered dependent's injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the overpayment. The Plan may assert this right independently of you or the covered dependent.

You or the covered dependent are obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you or the covered dependent enters into litigation or settlement negotiations regarding the obligations of other parties, you or the covered dependent must not prejudice, in any way, the subrogation rights of the Plan under this section.

WHEN COVERAGE ENDS

Your Coverage

Coverage under the IBM Plan's medical, dental and vision options ends in *the month you separate as follows:*

- If you are enrolled in a fully insured option (i.e., HMO), active coverage usually ends on the last day of the month in which you separate.
- If you are enrolled in a self-insured option (i.e., IBM PPO, IBM PPO Plus, etc.) active coverage will end on the 15th of the month in which you separate if the separation date is between the 1st and the 15th of the month. If you separate after the 15th of the month, coverage will end on the last day of the month.

The above will apply when any of the following occurs:

- Your regular IBM employment terminates.
- Your retiree supplemental or long-term supplemental IBM employment terminates.
- You begin an approved leave of absence without benefits.
- You retire (see *About Your Benefits: Post Employment* on w3 under "Legal Notices" for information about the benefits you may be eligible to receive).

When you begin Long Term Disability benefits (see *About Your Benefits: Post Employment* on w3 under "Legal Notices" for information about the benefits you may be eligible to receive), your coverage will end on the last day of the month in which your status is updated to Long Term Disability.

In the event of the employee's death:

- If there are no surviving dependents enrolled in the plans, coverage will end on the date of death.
- If there are surviving dependents enrolled in the plans, coverage remains in effect until the end of the month in which the employee died if the employee was enrolled in a fully insured option. If the employee was enrolled in a self-insured option, coverage will end on the 15th of the month if the date of death is between the 1st and 15th of the month. If the date of death is after the 15th of the month, coverage will end on the last day of the month.
- If there are surviving dependents enrolled in an HMO, coverage in these options will cease at the end of the month in which the employee died.

Please note that expenses incurred after the time coverage ceases are not eligible for benefits.

Your Dependents' Coverage

Your dependents' coverage will end on the last day of the payroll period, as described above, in which your active coverage terminates for any reason. In the event of your death, your surviving dependents may elect to continue coverage through the Transitional Medical Program.

In all other circumstances, your dependents' coverage will terminate at the end of the month for any of the following reasons:

- Your spouse loses eligibility for coverage as a result of divorce.
- The dissolution of your domestic partnership.
- Your dependent children lose eligibility for coverage as a result of their ceasing to meet any one of the criteria of eligible dependent below as a result of:
  - Reaching age 26.
  - No longer meeting disability requirements.
  - Any other reason for which they cease to meet the eligibility criteria.

COBRA Benefits through the Transitional Medical Program (TMP)

There are alternatives available to you, your spouse/domestic partner or your eligible family members for continuing coverage after eligibility ends under the IBM Plans. To continue coverage under any of the Plans for which you're eligible, you have the option to purchase continuation coverage for a limited time (generally up to 18 months or up to 36 months depending on the event that caused termination of benefits) at group rates through the Transitional Medical Program (TMP). For complete details about continuing coverage through the TMP, see "Transitional Medical Program (TMP)" later in this section. Please note the terms TMP and COBRA are used interchangeably throughout this section.

Converting Your Coverage

There is no conversion privilege under the IBM PPO, IBM PPO Plus, IBM Exclusive Provider Organization, IBM PPO with HSA, or IBM Enhanced PPO with HSA. TMP is the only option to continue coverage when your coverage under any of these options ceases.

If you have been receiving your medical and/or dental coverage through an HMO, you can request further information on conversion privileges directly from the HMO.

TRANSITIONAL MEDICAL PROGRAM (TMP)

To continue coverage under the Plan, you have the option to purchase continuation coverage for a limited time (generally up to 18 months or up to 36 months depending on the event that caused termination of benefits) at group rates through the Transitional Medical Program (TMP). TMP satisfies the requirements of federal legislation entitled the *Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA,* and follows the mandates established by this law. COBRA continuation coverage is a temporary continuation of health care coverage when coverage would end because of a life event, known as a "qualifying event."

Qualified Beneficiaries

COBRA continuation coverage must be offered to each "qualified beneficiary." A qualified beneficiary is any individual who, on the day before the qualifying event, is covered under the IBM group health plans because he or she is a covered employee or dependent of a covered employee. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the IBM group health plans is lost because of a qualifying event. Each qualified beneficiary has an independent right to elect COBRA

continuation coverage. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation coverage period.

You are qualified to purchase TMP if you lose coverage under the IBM group health plans for any of the following reasons:

- You are an employee participating in the plans and
  - Your employment terminates (including retirement) other than for gross misconduct, or
  - You begin an approved leave of absence without health care benefits or
  - Your employment status changes to part-time or non-regular and no health care benefits are provided.
- Your dependents are qualified to purchase TMP if they lose coverage under the IBM group health plans for any of the following reasons
  - Your employment status ends or changes as described above
  - You and your spouse divorce
  - You die while participating in the Plans as an employee and your spouse/dependents are not eligible for continuous health care benefits
  - Your child loses eligible dependent child status or
  - You become entitled to Medicare and opt out of the IBM group health plans.

Domestic Partners
Although not legally required to do so, IBM has decided to make continuation coverage available for purchase by a former domestic partner. The same rules (for example, the rules regarding notification of qualifying events and election of continuation coverage) apply as for a spouse.

If you are covered by the San Francisco Equal Benefits Ordinance, see section titled San Francisco, CA, Equal Benefits Ordinance (EBO) for more information on continuation coverage.

When Continuation Coverage Is Available
The IBM health plans offer continuation coverage to qualified beneficiaries through TMP *only after* the COBRA administrator has been notified that a qualifying event has occurred.

Notification of Qualifying Events
When the qualifying event is the termination of employment, the employment status changes described previously or the employee's death, *the employer must notify* the COBRA administrator of the qualifying event.

The employee, qualified beneficiary or the employee's or qualified beneficiary's representative must notify the COBRA administrator when the qualifying event is:

- Divorce of the covered employee and his or her spouse.
- Dependent child losing eligible-dependent child status.
- A second qualifying event after a qualified beneficiary has become entitled to COBRA continuation coverage through TMP. For example, you terminate employment (other than for gross misconduct). You, your spouse and dependents elect continuation coverage through TMP for a maximum period of 18 months. During the continuation coverage period, you die. Your spouse and dependents have experienced a second qualifying event (your death) and may elect to receive a maximum of 36 months of COBRA continuation coverage.

- Determination of a qualified beneficiary's (who is entitled to receive a maximum of 18 months of COBRA continuation coverage) disability by the Social Security Administration during the first sixty (60) days of COBRA continuation coverage.
- Determination by the Social Security Administration that a qualified beneficiary is no longer disabled.

The employee, qualified beneficiary, or representative should notify the COBRA administrator of the qualifying event by calling the IBM Benefits Center – Provided by Fidelity.

Timing of Notification of a Qualifying Event
With respect to divorce, a child losing eligible dependent child status and the occurrence of a second qualifying event, the employee, qualified beneficiary or representative must notify the COBRA administrator within 60 days from the later of:

- The date of the qualifying event, or
- The date that the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event.

If notification of the qualifying event is not provided within the time period set out above, the individual affected will lose his or her right to COBRA continuation coverage. The individual affected will not be able to enroll in TMP and will be responsible for all health care expenses incurred after medical coverage ends.

With respect to a disability determination, the qualified beneficiary must provide notification of the disability determination within 60 days after the latest of:

- The date of the Social Security Administration disability determination;
- The date on which the qualifying event occurs; or
- The date on which the qualified beneficiary loses (or would lose) coverage due to the qualifying event.

The qualified beneficiary must provide notification to the COBRA administrator of the disability determination before the end of the initial 18 months of COBRA coverage.

If an individual received a Social Security Administration disability determination before his or her qualifying event, and he or she has not received a subsequent Social Security Administration determination that he or she is no longer disabled, then he or she has 60 days from the date of the qualifying event to provide notice of disability.

With respect to a determination by the Social Security Administration that a qualified beneficiary is no longer disabled, notification must be provided within 30 days after the date of the Social Security Administration's final determination that a qualified beneficiary is no longer disabled.

Summary of Notification Rules

Qualifying Event	Contact the COBRA Administrator Within 60 Days
▪ Divorce ▪ A child losing eligible dependent child status ▪ The occurrence of second qualifying event	You, your qualified beneficiary or representative must notify the COBRA Administrator within 60 days of the later of: ▪ The date of the qualifying event or ▪ The date that the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event.

Qualifying Event	Contact the COBRA Administrator Within 60 Days
▪ Disability determination	The qualified beneficiary must notify the COBRA Administrator of the disability determination within 60 days of: ▪ The date of the Social Security Administration disability determination ▪ The date on which the qualifying event occurs or ▪ The date on which the qualified beneficiary loses (or would lose) coverage due to the qualifying event.

How to Elect COBRA Continuation Coverage

The time for enrolling in COBRA continuation coverage expires 60 days after the date of the official TMP notification from the IBM Benefits Center or 60 days after the individual's IBM coverage ceases, whichever is later.

To enroll in COBRA continuation coverage, log in to NetBenefits or call the IBM Benefits Center – Provided by Fidelity.

If COBRA continuation coverage is not elected within the time period set out above, the individual affected will lose his or her right to COBRA continuation coverage. The individual affected will not be able to enroll in TMP and will be responsible for all health care expenses incurred after medical coverage ends.

No physical examination or other evidence of insurability is required to enroll in TMP.

How TMP Continuation Coverage Is Offered

After the COBRA administrator receives notice that a qualifying event has occurred, TMP continuation coverage is offered to each qualified beneficiary. The COBRA administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event and each qualified beneficiary has an independent right to elect TMP continuation coverage.

Covered employees may elect TMP continuation coverage on behalf of their spouses and parents may elect TMP continuation coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the COBRA administrator to ensure that you receive a COBRA enrollment notice following a qualifying event and to protect your family's rights.

Duration of TMP Continuation Coverage

TMP continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- The death of the employee.
- The divorce of the covered employee and his or her spouse.
- A dependent child losing eligible dependent child status.
- The employee's entitlement to Medicare benefits.

When the qualifying event is the termination of employment or an employment status change (such as a reduction of the employee's hours of employment), COBRA continuation coverage generally lasts for up to a total of 18 months. This 18-month period of COBRA continuation coverage can be extended under certain circumstances, as explained in the next section.

Disability Extension of 18-Month Period of Continuation Coverage

If a qualified beneficiary covered under the IBM health plan(s) is determined by the Social Security Administration to be disabled and you notify the COBRA administrator in a timely manner as described

previously, then you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, up to a maximum of 29 months of coverage. In order for this disability extension to apply, all of the following conditions must be met:

- Your COBRA qualifying event was a termination of employment or reduction in hours of employment.
- The disability started at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the COBRA administrator within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.
- An increased premium of up to 150% of the monthly cost of coverage is paid, beginning with the 19th month of coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage
If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly provided. You, your spouse and/or your dependent children must notify the IBM Benefits Center - Provided by Fidelity within 60 days of the date of the second qualifying event.

This extension may be available to your spouse and any dependent children receiving continuation coverage if you die, get divorced, become entitled to Medicare or if your dependent child loses eligible dependent child status, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Qualifying Events

Qualifying Event	Maximum Continuation Period		
	You	Your Spouse	Your Covered Children
You lose coverage because of an employment status change (reduced work hours) or taking an approved leave	18 months	18 months	18 months
You terminate employment for any reason (except gross misconduct)	18 months	18 months	18 months
You become entitled to Medicare	N/A	36 months	36 months
You or your dependent is disabled – as defined by the Social Security Act – at the time of the qualifying event or during the first 60 days of COBRA continuation coverage	29 months (initial 18 months, plus additional 11 months)	29 months (initial 18 months, plus additional 11 months)	29 months (initial 18 months, plus additional 11 months)
Your covered child loses eligible dependent child status	N/A	N/A	36 months
You die	N/A	36 months	36 months
You and your spouse divorce	N/A	36 months	36 months

If a covered employee becomes entitled to Medicare, and within 18 months of becoming entitled to Medicare, he or she becomes entitled to COBRA continuation coverage due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the covered employee's dependents may be continued for up to 36 months from the date the covered employee became entitled to Medicare.

If you are eligible for Trade Act Assistance ("TAA") or alternative Trade Act Assistance ("ATAA") and did not elect COBRA continuation coverage during the COBRA election period that applied to your loss of health care coverage due to your separation from employment, then you may have an additional COBRA election period. You may elect COBRA continuation coverage during the 60-day period that starts on the first day of the month that you become a TAA- or ATAA-eligible individual. Your election for COBRA continuation coverage must not be made later than six (6) months after the date of the TAA/ATAA-related loss of coverage (the date that you lost health care coverage due to your separation from employment that gives rise to you being a TAA- or ATAA-eligible individual).

What COBRA Coverage Costs

COBRA participants who elect TMP coverage must pay monthly premiums for this coverage. The cost of COBRA continuation coverage is 102% of the applicable premium for the plan(s) for the current plan year. Premiums are based on the full premium cost per covered person set at the beginning of the year, plus 2% for administrative costs.

Payment is due at enrollment, but there is a 45-day grace period from the date you elect COBRA continuation coverage to make the initial payment. The initial payment includes:

- Payments for coverage from the date of your loss of coverage through to the date you elect COBRA coverage and
- Any regularly scheduled monthly payment(s) that become(s) due between the date that you elected COBRA coverage and the end of the 45-day period.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1st, but will be accepted if postmarked by June 30th). If payment is not received within this grace period, coverage will be terminated as of the end of the last month in which full payment was received.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll free at 866-628-4282. TTD/TTY callers may call toll free at 866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Additional Information

If you or your dependent elects COBRA continuation coverage, it is effective as of the date of the qualifying event, unless you waive COBRA coverage and then revoke the waiver within the 60-day election period. In this case, your elected coverage begins on the date you revoke your waiver of the qualifying event.

You or your dependent may change your coverage:

- During your benefits renewal period.
- If you have a qualified change in status or another change in circumstance recognized by the Internal Revenue Service (IRS) and IBM.
- You may enroll any newly-eligible spouse or child under plan rules.

When COBRA Coverage Ends

COBRA continuation coverage will end on the earliest of the following dates:

- The date the applicable period of COBRA continuation coverage is exhausted.
- The date that you, your spouse or any of your covered dependents (including any domestic partner or children of a domestic partner) become covered under another health benefits plan not offered by IBM, provided the plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary. If it does, COBRA coverage for that pre-existing condition continues as long as you pay the premium.
- The date IBM stops providing group health coverage to any employee.

If a qualified beneficiary becomes entitled to Medicare after the date that COBRA continuation coverage is elected for him or her, then the qualified beneficiary's COBRA continuation coverage may be terminated on the date of his or her Medicare entitlement.

Continuation coverage also may be terminated for any reason that the IBM health plan(s) would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

To voluntarily terminate COBRA coverage, you must call the IBM Benefits Center – Provided by Fidelity. The effective date will be the first of the month following the call.

If You Have Questions

If you have questions about COBRA, please call the IBM Benefits Center – Provided by Fidelity.

You may also write to:

IBM Benefits Center
COBRA/TMP Administration
P.O. Box 77003
Cincinnati, OH 45277-0065

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's web site.

SURVIVOR BENEFITS

Normally, when an eligible regular employee dies (regardless of whether active or inactive), eligibility for health care coverage under the IBM Plans can continue for the surviving spouse/eligible surviving domestic partner and the decedent's eligible children under the Transitional Medical Program (TMP). For one year from the date of death, contributions will continue at the active rate and IBM will subsidize the remaining portion of the cost. Continuation of benefits is available at full TMP rates thereafter for the remainder of the TMP period.

However, if the employee, on the date of his or her death, either (1) was age 55 or older and had 15 or more years of service, or (2) had 30 or more years of service regardless of age, *and* was within five years of meeting either of these criteria as of June 30, 1999, eligibility for coverage will continue instead under the prior IBM retiree medical program (see *About Your Benefits: Post Employment* on w3 under "Legal Notices").

In such cases, eligibility continues for:

- The surviving eligible spouse as determined by the terms of the Plan in effect at the time of death, and as may be modified thereafter.
- The surviving eligible domestic partner, provided a valid affidavit (or other comparable state certificate that legalizes your relationship) is in effect, as determined by the terms of the Plan in effect at the time of death and as may be modified thereafter.
- The decedent's eligible children for as long as they would have been eligible if the employee had not died, as determined by the terms of the Plan in effect at the time of death, and as may be modified thereafter.

If you are eligible for coverage under the Future Health Account, please refer to the summary plan descriptions *About Your Benefits: Future Health Account* and *About your Benefits: Post Employment* on w3 under "Legal Notices."

IBM Medical Coverage

IBM Medical Coverage

ABOUT YOUR MEDICAL COVERAGE

IBM offers eligible employees, and their eligible family members, medical coverage through the IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees. The IBM medical options provide comprehensive coverage for preventive care, medical care, hospitalizations and emergency care. What differs is how you access that care and the out-of-pocket cost you pay for covered services.

All of your IBM medical options provide coverage for:

- Eligible medical services — including 100% in-network coverage for eligible preventive care and 100% in-network coverage for primary care. Out-of-network services are generally not covered (see "Out-of-Network Medical Coverage" for details).
- Telemedicine services.
- Prescription drugs when purchased through CVS Caremark (mail order or retail) or through a pharmacy in the CVS Caremark network.
- Mental health/substance use care (out-of-network non-urgent residential and day rehabilitation services that are out of state or the immediate bordering state are generally not covered).
- Care coordination, condition management and decision support.

Note: No pre-existing condition exclusion applies to coverage under any of the IBM Plan medical options. Eligibility of medical charges does not depend on whether the medical condition began before or after the employee started to participate in the Plan.

YOUR MEDICAL COVERAGE OPTIONS

IBM PPO and IBM PPO Plus

The IBM PPO and IBM PPO Plus options provide in-network coverage for preventive and routine care, medical, surgical and hospitalization expenses. There is no primary care physician (PCP) requirement, and you may see any in-network provider you choose without a referral. Generally, out-of-network coverage is not available (see "Out-of-Network Medical Coverage" for more details). If you choose to use an out-of-network provider for services under the IBM Plan (other than those detailed under "Out-of-Network Medical Coverage"), you must pay the full cost of the services you receive.

The IBM PPO and IBM PPO Plus options also include coverage for prescription drugs under the IBM Managed Pharmacy Program and mental health/substance use services under the IBM Managed Mental Health Care Program. Generally, if your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions.

IBM Exclusive Provider Organization (EPO)

The IBM EPO option provides coverage for preventive and routine care, medical, surgical and hospitalization expenses. The IBM EPO is an "in-network" only option, which means benefits are payable only if participants seek care exclusively from eligible doctors, hospitals and other providers that belong to the health plan's provider network. There is no coverage for services received outside the network except in emergencies. There is no primary care physician (PCP) requirement, and you may see any network provider you choose without a referral. There is a small deductible, and there are fixed copayments for emergency room visits and inpatient admissions for surgery or rehabilitation.

The IBM EPO option also includes coverage for prescription drugs and mental health/substance use services under the IBM Managed Pharmacy Program and IBM Managed Mental Health Care Program. If your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions. Note that mental health/substance use services coverage is different under the IBM EPO than the IBM PPO, IBM PPO Plus, IBM PPO with HSA and IBM Enhanced PPO with HSA options. Please review the applicable sections carefully.

IBM PPO with HSA and IBM Enhanced PPO with HSA

The IBM PPO with HSA and IBM Enhanced PPO with HSA options provide in-network coverage for preventive and routine care, medical, surgical and hospitalization expenses and prescription drugs. There is no primary care physician (PCP) requirement, and you may see any eligible provider you choose without a referral. You must meet the deductible before the Plan will provide medical, mental health/substance use or pharmacy benefits. Please note that the deductible works differently with this plan option when more than one person is enrolled. The family deductible must be met before any family member is eligible to receive a benefit. Generally, out-of-network coverage is not available (see "Out-of-Network Medical Coverage" for more details). If you choose to use a provider who does not participate in the network (other than for services detailed under "Out-of-Network Medical Coverage"), you must pay the full cost of the services you receive.

The IBM PPO with HSA and IBM Enhanced PPO with HSA also include in-network coverage for prescription drugs under the IBM Managed Pharmacy Program and mental health/substance use services under the IBM Managed Mental Health Care Program, *both of which are subject to the annual deductible.* If your medical provider/facility provides a medication as part of an office visit, inpatient stay or outpatient procedure, this medication is covered under the medical benefit, subject to the medical plan's cost-sharing provisions. You pay 100% of the cost for all services and prescription drugs until you satisfy the annual deductible. If more than one person is enrolled, the entire family deductible must be met before anyone is eligible to receive a benefit. Preventive drugs are not subject to the deductible when the plan option has a *Health Savings Account (HSA).*

Health Savings Account (HSA)

The IBM PPO with HSA and IBM Enhanced PPO with HSA options also allow you to contribute to a tax-advantaged Health Savings Account (HSA). The HSA is not part of the IBM Plan. The HSA provides a savings mechanism for both current and future health care needs, as unused contributions accumulate over time and can be used for future medical expenses. The HSA is your personal account and unused balances remaining at the end of the plan year remain in your account. You own your HSA and you take it with you when you leave IBM or retire.

Note: In order to make HSA contributions, you may not have other health coverage. For this purpose, "other health coverage" generally includes medical plans, flexible spending accounts (such as the IBM Health Care Spending Account), healthcare reimbursement arrangements, Medicaid and Medicare coverage. Other health coverage also includes coverage provided to you through your spouse's plan. For example, you would have impermissible other coverage (and you would not be eligible to contribute to an HSA) if your spouse enrolls in family coverage in a medical plan that is not a qualifying HDHP (unless your spouse's plan does not cover you); or your spouse enrolls in a general purpose flexible spending account that may be used to reimburse your expenses.

Health Maintenance Organization (HMO)

An HMO is a managed care option. You generally use the HMO's providers for all of your care, and typically pay a flat-dollar copayment or fee for each service. Generally, care is coordinated through a primary care physician who refers you to a specialist or hospital as needed. Depending on the geographic area in which you live, you may have the choice of enrolling in an HMO for the plan year. Each year, before the annual enrollment period, eligible employees will receive a list of HMOs offered through IBM

and available in their area. Employees should contact the HMO's membership services department for detailed information on specific HMO benefits.

IBM's dependent eligibility guidelines pertain to all benefit options under the IBM Plan, including HMOs, and are not subject to any state laws mandating coverage for anyone not included in IBM's list of eligible dependents. (Not all HMOs offer coverage to domestic partners. Please refer to the *Spouse and Domestic Partner Information Guide* available on NetBenefits, w3 and through the IBM Benefits Center – Provided by Fidelity for information about which HMOs offer coverage to domestic partners.)

Most HMOs offered through IBM are fully-insured by the insurance company that maintains the HMO network. When you join a fully-insured HMO, you are electing an alternative to IBM medical coverage and you are agreeing to obtain your coverage from that organization, not from an IBM Plan option. Claims disputes and appeals are handled by the HMO. If you enroll in an HMO, you will receive a summary plan description (which may be referred to as a *Group Service Agreement* or *Certificate of Coverage*) directly from the HMO. If you don't receive one, contact the HMO to request a copy.

IBM Global Assignee Medical Plan

If you are a U.S. employee on international assignment under the Global Mobility Framework or a U.S. employee who is a 100% Travel Auditor, your coverage under this plan will end, and you will automatically be enrolled in the IBM Global Assignee Medical Plan effective on either the 1st or 16th of the month (whichever comes first) after your status change is updated at the IBM Benefits Center. Your enrollment in the IBM Global Assignee Medical Plan enables your eligibility for this plan option. Your coverage for medical, dental, vision, pharmacy and mental health (including repatriation services and International EAP) through Cigna Global Health Benefits covers claims both inside and outside the United States.

Upon becoming eligible for the IBM Global Assignee Medical Plan, employees should contact Cigna Global Health Benefits directly for detailed information on their specific benefits. U.S. outbound employees must contact the IBM Benefits Center to enroll approved family members into the IBM Global Assignee Medical Plan. This Plan is fully-insured by Cigna Global Health Benefits, and when you are enrolled in this Plan, you receive an alternative to IBM medical coverage and are agreeing to obtain your coverage through Cigna Global Health Benefits, not from an IBM Plan option. You will be able to access a summary plan description (referred to as the *Certificate of Coverage*) directly from CignaEnvoy.com, the Cigna Global Health Benefits Portal. Dependent eligibility guidelines and benefit plan provisions for the IBM Global Assignee Medical Plan are subject to state laws in Delaware as described in the Cigna Global Health Benefits *Certificate of Coverage*. Employees will no longer be eligible for the IBM Global Assignee Medical Plan after the last day of the month following their return to US Payroll. At this point U.S. outbound employees returning to the U.S. will become eligible for the IBM Medical Plan options available in their market area. *Note: The Global Assignee Medical Plan does not qualify as a high deductible health plan and you cannot contribute to a Health Savings Account (HSA) while enrolled in the Global Assignee Medical Plan.*

No Coverage

If you have medical coverage elsewhere (for example, under your spouse's plan), you can elect "No Coverage" for the plan year and pay no monthly contribution. If you elect this option, you will be required to confirm that you have other coverage when you enroll *and* you will not be able to request coverage from IBM once the plan year starts unless you lose the coverage you had elsewhere as a result of a qualified status change.

Telemedicine
Telemedicine is a virtual visit with a doctor or healthcare professional, done at your convenience from your home, work or while traveling. This program is available to participants of Anthem, Aetna and United HealthCare, using their telemedicine services.

Each health plan administrator administers the service differently. Please contact your health plan administrator to review your benefit:

- With most plans there are no out-of-pocket fees for active employees and their dependents. If you are enrolled in the IBM PPO with HSA or IBM Enhanced PPO with HSA you will have to meet your deductible first.
- Based on varying state regulations around telemedicine, it is not available in all states. Your carrier can inform you whether you live in a state where the program is available.

For details and to create your personal account please visit your health care administrator's site.

IBM Managed Mental Health Care Program
Depending on the IBM medical option you elect, you may receive automatic coverage under the IBM Managed Mental Health Care Program (MMHC). The MMHC Program helps identify appropriate treatment for mental health and substance use disorder services and provides coverage for in-patient and out-patient treatment.

IBM Managed Pharmacy Program
If you are enrolled in the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA or IBM Enhanced PPO with HSA, you will receive automatic coverage under the IBM Managed Pharmacy Program. The IBM Managed Pharmacy Program provides competitive pricing on prescription drugs through a network of participating pharmacies and mail order services. Participants in fully-insured HMOs are not eligible to participate in this program but are eligible for prescription drug benefits under their HMO medical plan option.

Care Management Program
The Care Management Program gives you, and your covered family members, easy access to resources and support when you need medical care. The program offers assistance in two ways.

- *Care Coordination Services,* provided by your health plan. If you require treatment for a significant medical condition, serious illness or injury a registered nurse, called a Care Coordinator, specifically assigned to you and your family, can help you:
  - Learn more about your illness, medical condition or injury and understand your treatment options.
  - Prepare for a healthy pregnancy.
  - Help you prepare for doctor visits to facilitate more productive discussions about your care.
  - Provide discharge planning for your care after a hospital stay.
  - Precertify all inpatient admissions, including inpatient hospitals, inpatient skilled nursing facilities, inpatient rehabilitation centers, etc.
- *Chronic Condition Management Program,* provided by your health plan and Optum* (Depression Condition Management Only). If you are undergoing treatment for asthma, congestive heart failure, coronary artery disease, depression, musculoskeletal pain or diabetes, a personal Care Manager from your health plan or Optum can help you:
  - Learn about your condition and develop ways to manage it.
  - Understand your treatment options.

- Get the most out of visits with your doctor and other health care providers.
- Attain your personal health goals.

* If you are enrolled in an HMO condition management services are provided by your health plan.

Centers of Excellence
Depending on the IBM medical option you elect, as well as your regional medical plan administrator, you may have access to expert case management programs for orthopedic services, bariatric surgery, infertility services and transplants. If you will be receiving any of these services, call your regional health plan to speak to an expert case management nurse and discuss your options. The nurse will direct you to a Center of Excellence (COE), a medical facility recognized for delivering a best-in-class member experience, with more successful health outcomes. **In most cases, you must use a COE facility or your benefit will be lower or you may have not coverage, even if the facility is an in-network facility.**

IBM MEDICAL OPTIONS AT-A GLANCE

The following charts provide an overview of the key features of the IBM medical options and *what you pay* for covered services. If you obtain care out-of-network, you generally must pay the full cost of any services you receive. (See "Out-of-Network Medical Coverage" for more details.) Information about the HMOs available to IBM employees in certain geographic areas can be obtained directly from the HMO.

	IBM PPO (In-Network)	IBM PPO Plus (In-Network)	IBM EPO (In-Network Benefits Only)
Service			
Medical (You Pay)			
Annual Deductible	$1,600 Individual / $4,700 Family[1]	$500 Individual / $1,500 Family[1]	$250 Individual / $750 Family[1]
Annual Out-Of-Pocket Maximum	$7,500 Individual / $15,000 Family	$7,500 Individual / $15,000 Family	$7,500 Individual / $15,000 Family
Routine Preventive Care	0%, no deductible[1]	0%, no deductible[1]	0%, no deductible[1]
Primary Care Physician	0%, no deductible for office visits	0%, no deductible for office visits	0%, no deductible for office visits
Urgent Care	25%, after deductible	25%, after deductible	25%, after deductible
Maternity Care	0%, no deductible, pre/post-natal visits	0%, no deductible, pre/post-natal visits	0%, no deductible, pre-natal visits
Infertility Services	COE or if gap exception granted: 25% SCP, after deductible Non-COE: 45%, after deductible	COE or if gap exception granted: 25% SCP, after deductible Non-COE: 45%, after deductible	COE: 25% SCP, after deductible Non-COE: No coverage
Specialty Care Physician/Other Provider	25%, no deductible (office visit) 25%, after deductible (non-office visit)	25%, no deductible (office visit) 25%, after deductible (non-office visit)	25%, no deductible (office visit) 25%, after deductible (non-office visit)
Labs	20%, no deductible	20%, no deductible	20%, no deductible
X-ray	20%, after deductible	20%, after deductible	0%, after deductible
High Cost Imaging - CAT Scan/PET Scan/MRI	20%, after deductible; precertification required	20%, after deductible; precertification required	20%, after deductible; precertification required
Medical Supplies/Durable Medical Equipment	20%, after deductible	20%, after deductible	0%, after deductible

	IBM PPO (In-Network)	IBM PPO Plus (In-Network)	IBM EPO (In-Network Benefits Only)
Inpatient Hospitalization	Facility charges: 20%, after deductible Professional charges: 20% PCP, after deductible/25% SCP, after deductible	Facility charges: 20%, after deductible Professional charges: 20% PCP, after deductible/25% SCP, after deductible	$1,200 copay, after deductible[2]
Bariatric Surgery - Inpatient (Contact Plan Administrator)	COE Facility Charge: 20%, after deductible Non-COE Facility Charge: 45%, after deductible[2]	COE Facility Charge: 20%, after deductible Non-COE Facility Charge: 45%, after deductible[2]	COE facility charge: 100% coverage after $1,200 hospital copayment, after deductible Non-COE: no coverage
Bariatric Surgery - Outpatient (Contact Plan Administrator)	COE Facility Charge: 20%, after deductible Professional Charge: No charge PCP / 25% SCP, after deductible Non COE Facility Charge: 45%, after deductible[2]	COE Facility Charge: 20%, after deductible Professional Charge: No charge PCP / 25% SCP, after deductible Non COE Facility Charge: 45%, after deductible[2]	COE Facility Charge: 25%, after deductible Professional Charge: No charge PCP, no deductible / 25% SCP, after deductible Non-COE Facility Charge: no coverage
Inpatient COE applicable Orthopedic Surgery (knee and hip replacement, spinal fusion, etc.) (Contact Plan Administrator)	COE Facility Charge: 20%, after deductible Non-COE In-network Facility Charge: 30%, after deductible[2]	COE Facility Charge: 20%, after deductible Non-COE In-network Facility Charge: 30%, after deductible[2]	COE facility charge: 100% coverage after $1,200 hospital copayment, after deductible In-Network Non-COE: 10% coinsurance after $1,200 copayment after deductible
Outpatient COE applicable Orthopedic Surgery (knee and hip replacement, spinal fusion, etc.) (Contact Plan Administrator)	COE Facility Charge: 20%, after deductible Professional Charge: No charge PCP / 25% SCP, after deductible Non COE Facility Charge: 30%, after deductible[2]	COE Facility Charge: 20%, after deductible Professional Charge: No charge PCP / 25% SCP, after deductible Non COE Facility Charge: 30%, after deductible[2]	COE Facility Charge: 25%, after deductible In-Network non-COE facility charge: 35%, after deductible Professional Charge: No charge PCP, no deductible / 25% SCP, after deductible
Transplants	COE Facility Charge: 20%, after deductible Non-COE Facility Charge: 45%, after deductible	COE Facility Charge: 20%, after deductible Non-COE Facility Charge: 45%, after deductible	COE facility charge: 100% coverage, after $1,200 hospital copayment, after deductible Non-COE: no coverage
Outpatient Services (Surgical and Non-Surgical)*	Facility charges: 20%, after deductible Professional charges: No Charge PCP/25% SCP, after deductible	Facility charges: 20%, after deductible Professional charges: No Charge PCP/25% SCP, after deductible	Facility fees: 25%, after deductible Professional charges: No charge PCP/25% SCP, after deductible
Emergency Room	20%, after deductible PLUS $150 copay (copay waived if admitted) Physician fees: 20% PCP, after deductible, 25% SCP, after deductible	20%, after deductible PLUS $150 copay (copay waived if admitted) Physician fees: 20% PCP, after deductible, 25% SCP, after deductible	$220 copayment, after deductible, waived if admitted.[3] If not admitted, an additional $150 payment, after deductible will apply.

[1]Annual deductible applies to medical and mental health/substance use services combined.

[2]Transplant, bariatric, infertility and orthopedic services must be received at a Center of Excellence (COE) to receive the highest benefit level. Contact your Plan Administrator for more information.

IBM PPO (In-Network)	IBM PPO Plus (In-Network)	IBM EPO (In-Network Benefits Only)
[3]Out-of-network emergency room visits for emergency care will be covered at in-network level of coverage, there is no out-of-network emergency room coverage for non-emergencies. *Out-of-Network claims incurred by members in an Out-of-Area (OOA) plan option and claims received from non US providers are paid based on billed rate. *All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate.		

	IBM PPO with HSA (In-Network)	IBM Enhanced PPO with HSA (In-Network)
Service		
Medical (You Pay)		
Annual Deductible	$2,700 Individual / $5,800 Family In and Out of Network Combined Includes MH/SU and RX[2]	$1,500 Individual / $3,000 Family In and Out of Network Combined Includes MH/SU and RX[2]
Annual Out-Of-Pocket Maximum	$6,650 Individual / $13,300 Family Includes MH/SU & Rx Embedded OOP Max*	$6,650 Individual / $13,300 Family Includes MH/SU & Rx Embedded OOP Max*
Routine Preventive Care	0%, no deductible	0%, no deductible
Primary Care Physician	0%, after deductible for office visits	0%, after deductible for office visits
Urgent Care	25%, after deductible	25%, after deductible
Maternity Care	0%, no deductible, pre/post-natal visits	0%, no deductible, pre/post-natal visits
Infertility Services	COE or with gap exception Inpatient: 25%, after deductible Outpatient: 30%, after deductible Non-COE: 45%, after deductible	COE or with gap exception Inpatient: 25%, after deductible Outpatient: 30%, after deductible Non-COE: 45%, after deductible
Specialty Care Physician/Other Provider	25%, after deductible including office visit, inpatient services and Urgent Care clinics 30%, after deductible outpatient services and surgery	25%, after deductible including office visit, inpatient services and Urgent Care clinics 30%, after deductible outpatient services and surgery
Labs	Inpatient: 25%, after deductible All other: 30%, after deductible	Inpatient: 25%, after deductible All other: 30%, after deductible
X-ray	Inpatient: 25%, after deductible All other: 30%, after deductible	Inpatient: 25%, after deductible All other: 30%, after deductible
High Cost Imaging - CAT Scan/PET Scan/MRI	30%, after deductible; precertification required[1]	30%, after deductible; precertification required[1]
Medical Supplies/Durable Medical Equipment	Inpatient: 25%, after deductible Outpatient: 30%, after deductible	Inpatient: 25%, after deductible Outpatient: 30%, after deductible
Inpatient Hospitalization	25%, after deductible, including professional charges	25%, after deductible, including professional charges
Bariatric Surgery - Inpatient (Contact Plan Administrator)	COE Facility Charge: 25%, after deductible Professional Charges: No charge PCP, after deductible/25% SCP, after deductible Non-COE Facility Charge: 45%, after deductible	COE Facility Charge: 25%, after deductible Professional Charges: No charge PCP, after deductible/25% SCP, after deductible Non-COE Facility Charge: 45%, after deductible

	IBM PPO with HSA (In-Network)	IBM Enhanced PPO with HSA (In-Network)
Bariatric Surgery - Outpatient (Contact Plan Administrator)	COE Facility Charge: 30%, after deductible Professional Charge: No charge PCP / 30% SCP, after deductible Non-COE Facility Charge: 45%, after deductible	COE Facility Charge: 30%, after deductible Professional Charge: No charge PCP / 30% SCP, after deductible Non-COE Facility Charge: 45%, after deductible
Inpatient COE applicable Orthopedic Surgery (knee and hip replacement, spinal fusion, etc.) (Contact Plan Administrator)	COE Facility Charge: 25%, after deductible Non-COE Facility Charge: 35%, after deductible	COE Facility Charge: 25%, after deductible Non-COE Facility Charge: 35%, after deductible
Outpatient COE applicable Orthopedic Surgery (knee and hip replacement, spinal fusion, etc.) (Contact Plan Administrator)	COE Facility Charge: 30%, after deductible Professional Charge: No charge PCP / 30% SCP, after deductible Non COE Facility Charge: 40%, after deductible	COE Facility Charge: 30%, after deductible Professional Charge: No charge PCP / 30% SCP, after deductible Non COE Facility Charge: 40%, after deductible
Transplants	COE Facility Charge Inpatient: 25%, after deductible Outpatient: 30%, after deductible	COE Facility Charge Inpatient: 25%, after deductible Outpatient: 30%, after deductible
Outpatient Services (Surgical and Non-Surgical)*	Facility charges: 30%, after deductible Professional charges: No charge PCP, after deductible/30% SCP, after deductible	Facility charges: 30%, after deductible Professional charges: No charge PCP, after deductible/30% SCP, after deductible
Emergency Room	30%, after deductible, PLUS $150 copay (copay waived if admitted) Physician fees 30%, after deductible	30%, after deductible, PLUS $150 copay (copay waived if admitted) Physician fees 30%, after deductible

[1]Precertification is required for non-emergency high cost diagnostic services such as CT scans, MRIs, PET scans, sleep studies, and cardiac studies for the IBM plan to pay a benefit.
[2]Annual deductible applies to medical, mental health/substance use and prescription drug services combined. You must meet the annual deductible before the Plan will provide coverage for these services, except routine preventive care services and medications. If more than one individual is enrolled, all family members must meet the combined family deductible before the Plan will begin to provide coverage for non routine preventive care services and medication.
*All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate.

IMPORTANT TERMS

- *Annual Benefit Maximum:* The maximum dollar amount or number of treatments that a plan (not you) will cover in a calendar year. If your expenses exceed the maximum, you will pay the rest. Different types of services may have individual annual maximums. There are separate annual benefit maximums for each covered family member.
- *Annual Deductible:* The annual deductible is the amount you must pay each calendar year before the Plan begins to pay benefits for covered medical, mental health and substance use expenses for you or your covered family members. There are two types of annual deductibles: individual and family. If more than one person is enrolled the family deductible must be met before the Plan begins to provide coverage. The annual deductible is applied to the out-of-pocket maximum. The annual deductible for health plans with an HSA also includes non-preventive prescription drug expenses.

- *Annual Out-of-Pocket Maximum:* The maximum amount you will pay for eligible medical, mental health/substance use and prescription drug expenses under your health plan in a calendar year. After you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the plan year. When the annual out-of-pocket maximum is reached, if the annual deductible is not satisfied, it will be deemed to be satisfied.
- *Care Coordinator:* Care Coordinators are Registered Nurses who perform care coordination/care management services and have substantial clinical experience specializing in complex situations. They are supported by Board-Certified physicians and also have access to medical specialists so they can identify appropriate medical practices related specifically to your condition.
- *Center of Excellence:* A medical facility recognized for delivering a best-in-class member experience for specific conditions, with more successful health outcomes.
- *Coinsurance:* Coinsurance is the amount of the medical, mental health or substance use expenses that you pay after you have met the annual deductible, expressed as a percentage of the provider's negotiated fee or actual charge. Coinsurance amounts count toward your out-of-pocket maximum.
- *Copayment:* Copayment is the amount you pay for medical, mental health or substance use services or prescription drugs, expressed as a flat dollar amount.
- *Discounted Fees:* Negotiated fees charged by in-network providers for services.
- *Formulary:* A list of preferred prescription drugs reviewed and approved for clinical effectiveness by an independent panel of doctors and pharmacists at the organization providing the prescription drug coverage. If your drug is on the formulary, the plan will pay a greater benefit than for a drug that is not on the formulary.
- *Out-of-Network Provider:* Sometimes referred to as a non-network provider or non-participating provider, these are doctors, hospitals, specialists, labs, retail pharmacies and other health care professionals or facilities that do not participate in your health plan's network. Generally, the Plan does not cover services provided by out-of-network providers.
- *Out-of-Pocket Costs:* The amount you pay with your own money for covered expenses. This includes deductibles, coinsurance and copayments.
- *Preauthorization.* Certain medical treatments need prior approval before the plan will cover them. This requirement is to ensure the treatment is appropriate, effective and medically necessary for the condition or diagnosis. If you do not receive approval, you will be responsible for paying the full cost of the treatment. Contact the health plan administrator for details.
- *Precertification:* Advance notification required by the Plan for approval of services such as certain major diagnostic services, such as CT scans and MTAs, a scheduled inpatient hospital stay, inpatient surgery, bariatric surgery, organ transplant, home health care, certain orthopedic surgeries, infertility treatment, extended care (skilled nursing facility) and rehabilitation facility admissions. For an inpatient admission following an emergency room visit, notification must be made to the health plan administrator within 48 hours of the admission.
- *Predetermination of Benefits:* Medical information (Current Procedural Terminology (CPT) codes; amount of charges; diagnosis; doctor's zip code and, if required, clinical documentation) submitted to the health plan for the purpose of determining eligibility of treatment ahead of time, as well as anticipated out-of-pocket expenses.
- *Primary Care Physician (PCP).* A physician (MD or DO) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, pediatric medicine; or, physician assistant or nurse practitioner, who provides care in an outpatient setting that promotes on-going care such as an office, outpatient surgery, retail walk-in clinic, nursing facility or home. Physician assistants and nurse practitioners are considered PCPs as long as they are employed and supervised by a licensed physician and submit charges through a PCP.

- *Prior Authorization.* Certain prescription drugs require your physician to obtain approval from the Pharmacy plan administrator to ensure the Plan will provide coverage for the specific medication for the patient. If you fail to obtain prior authorization, you will be responsible for the entire non-negotiated cost of the prescription drug.

HOW THE IBM MEDICAL PLAN WORKS

In-Network Benefits

Beginning January 1, 2019, IBM's PPO options will cover in-network medical and pharmacy services only, removing benefits for most non-emergency out-of-network services. There are exceptions where out-of-network care will continue to be covered at the in-network rate, see "Out-of-Network Medical Coverage" for more details. Since the network providers' fees are negotiated (and generally lower), you are charged less. (Network fees are negotiated directly between the providers and the health plan administrators.) Your network provider files claims for you so you don't have to do the paperwork.

Please refer to your HMO (Kaiser, Humana Puerto Rico or UPMC)'s Benefits Booklet for information on out-of-network coverage in emergency situations.

Generally, routine preventive care is covered at 100%. Care provided by your in-network primary care physician is covered at 100% under the IBM PPO, IBM PPO Plus and IBM Exclusive Provider Organization (EPO) options (no deductible applies). For the IBM PPO with HSA and the IBM Enhanced PPO with HSA, care provided by your in-network primary care physician is covered at 100% after satisfaction of the plan's deductible. After you satisfy the in-network annual deductible, other services may require you to pay a coinsurance amount until you reach the annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the IBM Medical Plan options pay 100% of the negotiated rate for eligible expenses received in-network for the remainder of the plan year. When the annual out-of-pocket maximum is reached, if the annual deductible is not satisfied, it will be deemed to be satisfied.

Most out-of-network mental health and substance use services are still covered under the IBM PPO plan options. See the IBM Mental Health Care Program section for details.

Out-of-Network Medical Coverage

Each time you need care, you can choose to see a provider who does not belong to the health plan's network. However, if you choose to see an out-of-network provider, you will be responsible for the full cost of the services. The Plan does not cover out-of-network medical expenses except for the following approved exceptions:

- **In an emergency.** An emergency is defined as the sudden onset of an acute medical condition that, without immediate medical care, could result in serious harm to your health, bodily functions or body parts (for example, sudden shortness of breath, uncontrolled bleeding, sudden severe intractable pain or any sudden onset of symptoms or illnesses a reasonable person would consider an emergency).
- **If you do not have the ability to choose an in-network provider**—for example, if you're receiving care at an in-network facility like a hospital, but select services are only available through an out-of-network provider (such as anesthesiology or pathology/laboratory services).
- Out-of-network coverage will still be available for mental health and substance use services, with a few important exceptions. Please refer to the "IBM Mental Health Care Program" section.
- You and your covered family members can still use an out-of-network provider if there isn't an in- network choice within a reasonable distance. If you think this applies to you, be sure to obtain approval from your medical plan before making an appointment with any out-of-network provider.

- **When a patient truly needs a hospital or provider for a unique condition that cannot be serviced by in-network providers.** If there are no in-network providers for the care you need, your medical plan will review the medical necessity of using out-of-network care. If the medical necessity for using out-of-network care is approved, an exception will be granted and the care will be covered as in-network. This is called a "Gap in Care" exception, and it requires approval before you seek out-of-network services. You will need to initiate that review process with your medical plan directly. If you have an exception already in place, revalidate it with your plan for 2019.
- **If you travel outside of the U.S., eligible charges incurred will be considered in-network.** Generally, you will pay for medical expenses incurred outside the U.S. at the time of service and then submit your claim for reimbursement, along with your itemized bill and other supporting documentation to your medical plan.
- **NOTE: Out-of-network lab or radiology services used by your provider will NOT be covered. This is the case even if your provider is in-network.** It's important to inform your providers (physician, specialist, labs, pharmacies, etc.) that your plan only covers services received from in-network providers. If your provider recommends you have a diagnostic test, see a specialist, get lab work done, have surgery etc., **it is your responsibility to make sure you use an in-network provider. If you do not use an in-network provider, the plan will not pay any benefits (other than those listed above) and you will be responsible for paying the full amount of the bill.**

If you have an out-of-network claim for one of the above circumstances, please refer to the section on "Out-of-Network Medical Claims with Approved Exceptions" for additional details on how your claim will be paid.

For more information, visit the Benefits Center on CaféWell.

Most out-of-network mental health and substance use services are still covered under the IBM PPO plan options. See the IBM Mental Health Care Program section for details.

Transition/Continuation of Care
If as of December 31, 2018, you were using out-of-network providers for hospitalizations, pregnancy, long- term illnesses etc., you may qualify for transition/continuation of care. Contact your medical plan directly for more details and to begin the transition of care process.

View the 2019 FAQs at ibmurl.hursley.ibm.com/OGMC for more details.

IF YOU LIVE OUTSIDE THE NETWORK AREA

In certain limited areas, a robust provider network is not available. Affected employees will be eligible for an Out-of-Area option administered by United HealthCare which provides the same benefits coverage described in this Summary Plan Description, but will provide reimbursement for covered services at the in-network level, based on the provider's actual charge. If this situation applies to you, it will be indicated in your enrollment materials.

Those living in areas designated as Out-of-Area are offered the same PPO plan options offered to all US plan members. The IBM EPO is not available in Out-of-Area areas.

Prescription drug and mental health/substance use benefits remain subject to the in-network and out-of-network requirements, as described in the "IBM Managed Pharmacy Program" and "IBM Managed Mental Health Care Program" sections of this book.

Provider Networks

Enrollees in the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA options have access to provider networks for hospitals, facilities, physicians and other health care providers, based on the region serviced by the health plan administrator. In-Network providers have agreed to negotiated fees. The health plan's provider networks are separate from each other and from the provider network available under the IBM Managed Mental Health Care and IBM Managed Pharmacy Programs.

If You Travel Within the U.S.

The health plan administrators have national networks that also cover areas outside of the regional areas in which the health plan options are offered. If you are traveling, or have a child away at school, there may be network providers available so you can take advantage of the in-network level of benefit. You should contact your health plan administrator for assistance in identifying these in-network providers.

If You Travel Outside of the U.S.

Eligible charges incurred while traveling outside of the United States will be considered at the in-network reimbursement level of benefits. Exchange rates will be taken from a recognized exchange rate publication selected by the health plan. The exchange rate used for reimbursement will be the rate effective on the date the service was rendered.

Generally, you will pay for medical expenses incurred outside the United States at the time of service and then submit your claim for reimbursement along with your itemized bill and other supporting documentation to your administrator of your plan option.

Health Plan Administrators

IBM's plan options are administered on a regional basis, where the health plan was selected based on a "best in market" approach. That means your health plan administrator depends on where you live, regardless of the option in which you are enrolled. The following chart lists each health plan and their assigned regional areas.

Health Plan Administrators by Regional Location				
AETNA	▪ Arkansas ▪ Colorado	▪ Connecticut ▪ Delaware	▪ New Jersey ▪ Oklahoma	▪ Texas
ANTHEM	▪ Alabama ▪ California ▪ Georgia ▪ Hawaii ▪ Illinois ▪ Indiana ▪ Iowa	▪ Kansas ▪ Kentucky ▪ Louisiana ▪ Maine ▪ Massachusetts ▪ Michigan ▪ Minnesota	▪ Mississippi ▪ Missouri ▪ New Hampshire ▪ New York ▪ North Carolina ▪ North Dakota ▪ Ohio	▪ Pennsylvania ▪ Rhode Island ▪ South Carolina ▪ South Dakota ▪ Tennessee ▪ West Virginia
UNITEDHEALTHCARE	▪ Alaska ▪ Arizona ▪ District of Columbia ▪ Florida	▪ Idaho ▪ Maryland ▪ Montana ▪ Nebraska ▪ Nevada	▪ New Mexico ▪ Oregon ▪ Puerto Rico ▪ Utah ▪ Virginia	▪ Washington ▪ Wisconsin ▪ Wyoming

Note: If you reside in an Anthem market area, certain areas utilize an Alternate Network, and you must use an Alternate Network provider to obtain the in-network benefit level. These areas are:

Area	Alternate Network Name
Georgia	Blue Open Access POS
Kansas City, Kansas	Preferred Care Blue PPO
Kansas City, Missouri	Preferred Care Blue PPO
St. Louis, Missouri	Blue Access Choice
New Hampshire	BlueChoice Open Access POS
New York	Empire POS
Tennessee	Network S

The Live/Work Rule

In certain cases, different health plans may be available at your work and home locations, and you may be eligible to enroll in the plan available in your work location. This is known as the "Live/Work Rule." If you choose to enroll in the plan that is available in your work location, you and any family members you cover must receive care from providers who are members of your work location's health plan network to receive in-network benefits. *(Note: Your work location is considered to be your work address as shown in Blue Pages.)* You must call the IBM Benefits Center – Provided by Fidelity to enroll in the plan available in your work location; you cannot enroll in a work location plan using NetBenefits. In addition, these elections will not carry over from plan year to plan year.

PRECERTIFICATION

All inpatient hospitalizations, treatment at extended care facilities and other services listed here must be precertified and approved by the health plan administrator. You (or your attending physician's office or your representative, such as a family member or friend) *must* call to precertify your stay. Please note the IBM Managed Mental Health Care Program also has precertification requirements for inpatient and certain outpatient treatment. For details, see the "IBM Managed Mental Health Care Program" section of this Summary Plan Description.

You must precertify the following services:

- Outpatient, non-emergency major diagnostic services and procedures (see list in Precertification for Major Diagnostic Services section)
- Inpatient hospital admissions/surgeries
- Inpatient hospital stay for childbirth that exceeds 48 hours after a normal delivery or 96 hours after a Caesarean delivery
- Inpatient emergency admissions in the United States and Puerto Rico, precertification must be obtained within 48 hours of admission, including Saturdays and Sundays or the next business day
- Admissions to non-hospital facilities such as
  - Birthing centers
  - Skilled nursing facility admissions and
  - Rehabilitation facility admissions

INPATIENT MATERNITY ADMISSIONS

Under federal law, group health plans and insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean delivery. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable. You must call to precertify your hospital stay if it goes beyond the minimum length of stay as defined by law or you will be subject to a $150 penalty or more if the stay is determined not to be medically necessary.

Although not mandatory, it is strongly recommended that expectant mothers continue to notify their Care Coordinator about their pregnancy to ensure the well-being of both the mother and baby, as it provides them an opportunity to obtain valuable literature, speak with a Registered Nurse and ask questions that may not have occurred during an office visit with their doctor. This is especially important if it is a high-risk pregnancy.

Precertification for Inpatient Hospital Admissions

Scheduled inpatient hospital admissions and surgeries must be precertified by calling the health plan administrator. The precertification line is available 24 hours a day. In the event of an emergency admission, you or your representative (such as a family member or friend) must contact the health plan within 48 hours of the emergency admission. If the hospital offers to precertify on your behalf, they must call within 48 hours of the emergency, including Saturdays and Sundays.

If you fail to precertify a non-mental health inpatient hospital admission or fail to notify the health plan within 48 hours of an emergency admission, you will be charged a penalty of $150, even if your care is determined to be medically necessary and eligible for coverage. In addition, if some or all of your care is subsequently determined not to be eligible under the terms of the IBM Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the stay and treatment deemed not medically necessary. Only days that are medically necessary will be eligible for benefits consideration.

Note: This inpatient hospital precertification requirement does not apply to mental health/ substance use admissions (see "IBM Managed Mental Health Care Program" for inpatient mental health/substance use precertification details) and to admissions that occur outside of the United States and Puerto Rico. If IBM is not your primary source of coverage this requirement does not apply.

Precertification for Non-Hospital Facilities, Extended Care and Organ Transplants

If your physician has ordered any of the above services, you must contact your health plan to determine eligibility. The health plan's Care Coordinator is required to perform a medical care review and obtain medical information from your treating physician in order to determine if the services are medically necessary and eligible for coverage. Claims received for these services that have not been authorized will be denied. A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the services are subsequently determined not to be eligible under the terms of the Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services or care deemed not medically necessary. **You are required to obtain transplant services from a Center of Excellence to receive the highest level of benefit.**

Precertification for Bariatric (Gastric Bypass) Surgery

Precertification from your health plan administrator is required in order to obtain approval for bariatric (gastric bypass) surgery. If you, or a covered family member, are seeking approval for bariatric (gastric bypass) surgery, you should contact your health plan for a predetermination of benefits before scheduling the surgery. To receive approval for bariatric (gastric bypass) surgery, very specific medical

guidelines and criteria *must* be met, and your physician must provide all appropriate medical documentation and information. A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient. Medical records must include documentation of the physician's contemporaneous assessment of your progress throughout the course of treatment. **You are required to obtain bariatric services from a Center of Excellence to receive the highest level of benefit.**

Precertification for Major Diagnostic Services

Precertification is required for the following outpatient, non-emergency major diagnostic services and procedures:

- CT/CTA Scan
- MRI/MRA
- PET scan
- Nuclear medicine
- Echocardiogram (including stress echocardiogram)
- Sleep studies
- Cardiac catheterization
- Cardiac studies
- Electrophysiology implants
- Arterial ultrasound
- Percutaneous coronary intervention (stents, balloon angioplasty, atherectomy)

Since the exact list of services varies by plan, please ensure that you or your physician calls your Health Plan Administrator for more information before any of the listed tests or procedures are scheduled.

Precertification for Orthopedic Surgery

Precertification from your health plan administrator is required in order to obtain approval for orthopedic surgery. If you or a covered family member are seeking approval for orthopedic surgery, you should contact your health plan for a predetermination of benefits before scheduling the surgery. **For certain orthopedic procedures such as knee replacement, hip replacement and spinal fusion, you are required to obtain services from a Center of Excellence to receive the highest level of benefit.**

Precertification for Infertility Services

Precertification from your health plan administrator is required in order to obtain approval for infertility services. If you or a covered family member are seeking approval for infertility services, you should contact your health plan for a predetermination of benefits. In some instances, **you are required to obtain services from a Center of Excellence to receive the highest level of benefit.**

How to Obtain Precertification

You, your attending physician's office or personal representative such as a family member or friend must call the health plan to precertify an inpatient hospital admission or high-cost imaging procedure or notify the health plan within 48 hours of an emergency admission. To precertify all other services, contact the health plan as soon as possible in advance of the service to determine eligibility. In some cases, the provider may be responsible for precertifying in-network care. You should check with your health plan to determine if your provider will do this precertification for you. In all other cases, including for any covered out-of-network services, you must obtain the required precertification.

Utilization Reviews

The Plan requires the health plan administrators to perform utilization reviews to determine the medical necessity of an inpatient hospitalization, certain treatments or services obtained either in the hospital or outside a hospital, or eligibility of ongoing treatments or services.

This review may require a letter of medical necessity to determine eligibility. When a utilization review is performed, you and your health care providers must allow the health plan's Care Coordinators access to the patient's medical records and otherwise cooperate with the review procedures in order for benefits to be paid under the Plan. IBM may require such review before, during and/or after the inpatient hospitalization, treatment or other service.

Utilization reviews are performed by the health plan's Care Coordinators or their agents. IBM has no access to this information except with permission from you and/or the patient, or when necessary for the Plan Administrator to review a claim, or for statistical purposes in a form not identifying individuals or patients.

PREDETERMINATION OF BENEFITS

The IBM Medical Plan provides benefits only for eligible covered services as determined by the health plan and detailed in the "What's Covered Under the IBM Medical Plan" section. Guidelines have also been established on appropriate treatment for therapies which are reasonably necessary for the care and treatment of a medical condition when rendered by an eligible provider.

You are strongly urged to determine eligibility of services and fees before receiving treatment to ensure a clear understanding of all charges and reimbursements in advance. The lack of a predetermination may result in more out-of-pocket expense than you anticipated. You should contact the health plan to obtain a predetermination of coverage, particularly when any proposed treatment is expected to continue for any length of time. You or your doctor may be required to submit clinical data for the health plan to determine eligibility of services.

The following is only a sample of the treatment and therapies that might continue for a period of time, as well as an example of the typical duration of treatment:

- Biofeedback Therapy — up to a maximum of 20 visits
- Cardiac Rehab Therapy — up to a maximum of six months
- Continuous Passive Motion Therapy — up to a maximum of two weeks, must be utilized on a daily basis (for example: major knee or shoulder surgery)
- IV Therapy for Lyme Disease — up to a maximum of 28 days
- Physical Therapy* - up to a maximum of 40 visits per year
- Chiropractic Services - up to a maximum of 40 visits per year
- Occupational Therapy* - up to a maximum of 40 visits per year
- Speech Therapy* - up to a maximum of 40 visits per year.

* Medical Necessity review required for > 40 visits per year.

To request a predetermination of benefits coverage, call your health plan and provide any relevant information such as:

- Current Procedural Terminology (CPT) code (medical coding used to describe the particular service/procedure, available from your physician), or codes (if multiple surgical procedures are involved)

- Amount of charges
- Clinical information/medical records and
- ZIP code where treatment will be provided (for surgical services, the surgeon's ZIP code).

IBM PPO

The IBM PPO option covers you for a range of services, including preventive care, medical care, surgery, hospitalization emergency care, prescription drug and mental health and substance use services. Generally, you must satisfy an annual deductible before the Plan pays benefits for most eligible services. Under the IBM PPO you don't need to select a primary care physician (PCP) and you don't need a referral to see a specialist. There is generally no coverage for services received outside the network, except in emergencies and certain other situations, see "Out-of-Network Medical Coverage" for more information.

IBM PPO COVERAGE SUMMARY

The following chart shows what you pay under the IBM PPO option for covered services after you meet the applicable annual deductibles. If you obtain care out-of-network, you generally will be responsible for the full cost of services received.

	In-Network
Service	
Medical (You Pay)	
Routine Preventive Care	0%, no deductible
Primary Care Physician	0%, no deductible for office visits
Maternity Care	0%, no deductible, pre/post natal visits
Specialty Care Physician/Other Provider	25%, no deductible (office visit) 25%, after deductible (non-office visit)
Labs	20%, no deductible
X-ray	20%, after deductible
High Cost Imaging - CAT Scan/PET Scan/MRI	20%, after deductible; precertification required[1]
Medical Supplies/Durable Medical Equipment	20%, after deductible
Inpatient Hospitalization	Facility charges: 20%, after deductible Professional charges: 20% PCP, after deductible/25% SCP, after deductible[2]
Outpatient Services (Surgical and Non-Surgical)*	Facility charges: 20%, after deductible Professional charges: No Charge PCP/25% SCP, after deductible
Emergency Room	20%, after deductible PLUS $150 copay (copay waived if admitted)[3] Physician Fees 20% PCP, after deductible / 25% SCP, after deductible[3]

[1]Precertification is required for non-emergency high-cost diagnostic services such as CT scans, MRIs, PET scans, sleep studies, and cardiac studies for the IBM Plan to pay a benefit.

[2]Transplant, bariatric, infertility and orthopedic services must be received at a Center of Excellence (COE) to receive the highest benefit level.

[3]All emergency care is treated as in-network until individual is medically able to be moved to an in-network facility. Once individual is able to be moved, medical services received at the non-network facility are no longer covered.

*All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate.

ANNUAL DEDUCTIBLE

The IBM PPO requires you to satisfy an annual deductible before the Plan pays benefits. The annual deductible applies to mental health services but does not apply to the following services:

- Eligible routine preventive services
- Doctor's office visits (excluding hospital, urgent care or Emergency Room services), telemedicine visits and retail clinic
- Lab services
- Nutritional counseling and
- Prescription drug charges.

Annual Deductible

Once you, or your covered family member, meet the individual deductible, the Plan will pay the applicable percentage of eligible expenses you receive, based on the negotiated fee. The deductible does not apply to eligible routine preventive services and primary care office visits. As soon as any covered family member meets the individual deductible, the Plan will begin to pay for eligible expenses incurred for that person. The annual deductible counts toward the annual out-of-pocket maximum.

To limit a family's total deductible expenses during the year, a family need not satisfy more than three individual deductibles before benefits are paid for the entire family. Once the family deductible is reached, the Plan will pay eligible expenses for every covered family member at the applicable percentage, based on the type of service. Therefore, for families of four or more, it is possible to reach the family deductible before every person meets the individual deductible.

Expenses That Do Not Count Toward the IBM PPO Annual Deductible

- Prescription drug charges under the IBM Managed Pharmacy Program.
- Mental health and substance use charges that exceed 80% of the U&P rate.

ANNUAL OUT-OF-POCKET MAXIMUM

The IBM PPO limits how much you and your covered family members have to pay out of your own pocket each year for eligible medical expenses (including prescription drug and mental health). This is known as your annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the Plan will pay 100% of the negotiated fee or actual charges, or 80% of the U&P rate, whichever is less, for any additional eligible expenses for the remainder of the plan year.

Expenses That Do Not Count Toward the IBM PPO Annual Out-of-Pocket Maximum

- Penalties for purchasing a brand name drug when a generic drug with the same active ingredient is available under the IBM Managed Pharmacy Program.
- Mental health and substance use charges that exceed 80% of the U&P rate.

IBM PPO Plus

The IBM PPO Plus option covers you for a range of services, including preventive care, medical care, surgery, hospitalizations, emergency care, prescription drugs and mental health services. You must meet an annual deductible before the Plan pays benefits for most eligible services.

Under the IBM PPO Plus you don't need to select a primary care physician (PCP) and you don't need a referral to see a specialist. There is generally no coverage for services received outside the network, except in emergencies and certain other circumstances. See "Out-of-Network Medical Coverage," for more information.

IBM PPO PLUS COVERAGE SUMMARY

The following chart shows what you pay under the IBM PPO Plus option for covered services after you meet any applicable annual deductibles. If you obtain care out-of-network, you generally must pay the full cost of any services received.

	In-Network
Service	
Medical	
Routine Preventive Care	0%, no deductible
Primary Care Physician	0%, no deductible for office visits
Maternity Care	0%, no deductible, pre/post-natal visits
Specialty Care Physician/Other Provider	25%, no deductible (office visit) 25%, after deductible (non-office visit)
Labs	20%, no deductible
X-ray	20%, after deductible
High Cost Imaging - CAT Scan/PET Scan/MRI	20%, after deductible; precertification required
Medical Supplies/Durable Medical Equipment	20%, after deductible
Inpatient Hospitalization	Facility charges: 20%, after deductible Professional charges: 20% PCP, after deductible/25% SCP, after deductible
Outpatient Services (Surgical and Non-Surgical)*	Facility charges: 20%, after deductible Professional charges: No Charge PCP/25% SCP, after deductible
Emergency Room	20%, after deductible PLUS $150 copay (copay waived if admitted) Physician Fees: 20% PCP, after deductible / 25% SCP, after deductible
*All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate.	

ANNUAL DEDUCTIBLE

The IBM PPO Plus requires you to meet an annual deductible before the Plan pays benefits. The annual deductible also counts toward the annual out-of-pocket maximum. The annual medical deductible applies for mental health services but does not apply to the following services:

- Eligible routine preventive services
- Doctor's office visits (excluding hospital, urgent care and Emergency Room services), telemedicine or retail clinic Lab services
- Nutritional counseling and
- Prescription drug charges.

Expenses That Do Not Count Toward the IBM PPO Plus Annual Deductible

- Prescription Drug charges under the IBM Managed Pharmacy Program.
- Mental health and substance use charges that exceed 80% of the U&P rate.

ANNUAL OUT-OF-POCKET MAXIMUM

The IBM PPO Plus limits how much you and your covered family members have to pay out of your own pocket each year (including prescription drug and mental health). This is known as your annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the Plan will pay 100% of the negotiated fee or the actual charge or 80% of the U&P rate, whichever is less, for any additional eligible expenses for the remainder of the plan year.

Expenses That Do Not Count Toward the IBM PPO Plus Annual Out-of-Pocket Maximum

- Penalties for purchasing a brand name drug when a generic drug with the same active ingredient is available under the IBM Managed Pharmacy Program.

IBM Exclusive Provider Organization (EPO)

The IBM Exclusive Provider Organization (EPO) option is available only to employees who live within the network area. This option covers you for a range of services, including preventive care, medical care, surgery, hospitalizations, prescription drug and mental health services that you receive in-network only. You need to satisfy an annual deductible before the Plan pays benefits for most eligible services. Benefits are payable only if participants seek care exclusively from doctors, hospitals and other facilities that belong to the plan's provider network. There is no coverage for services received outside the network, except in emergencies.

Under the IBM EPO you don't need to select a primary care physician (PCP) or obtain a referral to see a specialist.

IBM EPO COVERAGE SUMMARY

The following chart shows what you pay under the IBM EPO option for covered services after you meet any applicable annual deductible. You are responsible for your portion of the coinsurance until you satisfy the annual out-of-pocket maximum. Care received outside of the Plan's provider network will not be covered, except in the case of an emergency.

	You Pay (In-Network Benefits Only)
Service	
Medical	
Routine Preventive Care	0%, no deductible
Primary Care Physician	0%, no deductible for office visits
Maternity Care	0%, no deductible, pre-natal visits
Specialty Care Physician/Other Provider	25%, no deductible (office visit) 25%, after deductible (non-office visit)
Labs	20%, no deductible
X-ray	0%, after deductible
High Cost Imaging - CAT Scan/PET Scan/MRI	20%, after deductible; precertification required
Medical Supplies/Durable Medical Equipment	0%, after deductible
Inpatient Hospitalization	$1,200 copay, after deductible[1]
Outpatient Services (Surgical and Non-Surgical)*	Facility fees: 25%, after deductible Professional charges: No charge PCP/25% SCP, after deductible

	You Pay (In-Network Benefits Only)
Emergency Room	$220 copay, after deductible, waived if admitted If not admitted, an additional $150 payment, after deductible will apply.

[1]Transplant, bariatric, infertility and orthopedic services must be received at a Center of Excellence (COE) to receive the highest benefit level. Contact your Plan Administrator for more information.

*All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate.

ANNUAL DEDUCTIBLE

In-Network Deductible

The IBM EPO requires you to satisfy an annual deductible before the Plan pays benefits for in-network services. The annual deductible also counts toward the annual out-of-pocket maximum. The annual medical deductible applies for mental health services but does not apply to the following services:

- Eligible routine preventive services
- Doctor's office visits (excluding hospital, urgent care and Emergency Room services), telemedicine or retail clinic
- Lab services
- Nutritional counseling and
- Prescription drug charges.

ANNUAL OUT-OF-POCKET MAXIMUM

The IBM EPO limits how much you and your covered family members have to pay out of your own pocket each year including prescription drug and mental health. This is known as your annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the Plan will pay 100% of the negotiated fee for any additional eligible expenses for the remainder of the plan year.

Expenses That Do Not Count Toward the IBM EPO Annual Out-of-Pocket Maximum

- Penalties for purchasing a brand name drug when a generic drug with the same active ingredient is available under the IBM Managed Pharmacy Program.

IN CASE OF AN EMERGENCY

The IBM Exclusive Provider Organization (EPO) option does not provide coverage for out-of-network medical services, unless they are received on an emergency basis. Emergency services received out-of-network will be paid at the in-network level. In case of an emergency, seek medical help first and then contact your health plan within 48 hours. Failure to contact your health plan may affect your coverage for out-of-network services.

IBM PPO with HSA, IBM Enhanced PPO with HSA for Active Employees

OVERVIEW OF THE IBM PPO WITH HSA, IBM ENHANCED PPO WITH HSA

Like the other IBM PPO options, the IBM PPO with HSA and IBM Enhanced PPO with HSA options provide coverage for medical, preventive, surgical, hospitalization, prescription drug and mental health/substance use services. However, the Plans also meet the Internal Revenue Service (IRS) definition of a High Deductible Health Plan (HDHP) and allow a qualifying participant to open their own Health

Savings Account (HSA) that enables you to set aside pretax dollars to pay for current and future eligible medical expenses.

Generally, you must meet an annual deductible before the Plan pays benefits. In addition, if more than one person is enrolled, the entire family deductible must be met before anyone is eligible to receive a benefit. Under the IBM PPO with HSA and the IBM Enhanced PPO with HSA you don't need to select a primary care physician (PCP) and you don't need a referral to see a specialist. Prescription drug coverage is provided under the IBM Managed Pharmacy Program administered by CVS Caremark. Mental health/substance use coverage is provided under the IBM Managed Mental Health Care Program administered by Optum.

Under the IBM PPO with HSA and IBM Enhanced PPO with HSA, you have the freedom to select any eligible provider (including providers for mental health/substance use treatment) and facility of your choice, each time you obtain care. However, there is generally no coverage for services received outside the network, except in emergencies and certain other circumstances. See "Out-of-Network Medical Coverage" for more information.

Health Savings Account (HSA)

A Health Savings Account (HSA) offers a unique, tax-advantaged way to pay for current eligible expenses and save for future health care expenses. An HSA also gives you the flexibility to save for future eligible health care expenses since any unused balance in your account remains invested and rolls over from year to year.

The HSA is *not* a benefit plan sponsored by IBM. Rather, it is a separate feature that can work together with the IBM PPO with HSA and IBM Enhanced PPO with HSA. If you enroll in one of these plan options, you will have the opportunity to open your HSA with Fidelity Investments during your enrollment.

Contributions to the HSA

Each year you enroll in the IBM PPO with HSA or IBM Enhanced PPO with HSA, IBM will make a contribution to your HSA. IBM's contribution is not treated as taxable income in most states. In addition, you can supplement IBM's contribution by making your own pretax contributions to your HSA account, up to the annual maximum limit. Moreover, if you are age 55 or older, you are also eligible to make an additional "catch-up" contribution each year, up to the annual maximum limit. IBM's contribution amount and current year employee and catch-up contribution limits are announced each year during annual enrollment. In order to make HSA contributions, you may not have other health coverage. For this purpose, "other health coverage" generally includes any health plan other than a high deductible health plan (HDHP) including medical plans, flexible spending accounts (such as the IBM Health Care Spending Account), healthcare reimbursement arrangements and Medicare coverage. Other health coverage also includes coverage provided to you through your spouse's plan. For example, you would have impermissible other coverage (and you would not be eligible to contribute to an HSA) if your spouse enrolls in family coverage in a medical plan that is not a qualifying HDHP (unless your spouse's plan does not cover you); or your spouse enrolls in a general purpose flexible spending account that may be used to reimburse your expenses.

If you are only eligible to make HSA contributions for a portion of the year, your annual HSA contribution limit, including IBM contributions, generally is prorated based on the number of months in which you are eligible to make HSA contributions on the first day of the month. However, you may contribute up to your annual limit at any time.

A participant in the IBM PPO with HSA or IBM Enhanced PPO with HSA must meet certain conditions and requirements to be eligible to establish an HSA. For more information about eligibility and the HSA in general, please refer to the *Health Savings Account Participant Information for Active Employees* pamphlet available on w3 and NetBenefits.

Contributions Summary:
Following the chart are details about how to receive IBM contributions and make your own employee contributions.

		HSA Plan Options		Non-HSA Plan Options
		Individual Coverage	**Family Coverage**	
IBM Gives You	**IBM base contributions**	$250	$500	**Not applicable**
	HSA Jump-Start Contribution	$250	$250	
You Earn	**Ready-Set-Go contribution** program completion on *CaféWell*	$300	$850	
	Total IBM contribution potential	$800	$1600	

IBM's Contributions: If you enroll in an HSA-eligible health plan option, IBM will contribute $250 to your HSA if you are enrolled in single coverage and $500 to your HSA if you are enrolled in family coverage. *(Note: For anyone hired during the year, IBM contributions will be prorated on a pay period by pay period basis.)* In addition, IBM will contribute a $250 Jump Start bonus to those who enroll in a HSA-eligible health plan option. Finally, if you enroll in an HSA-eligible health plan option, IBM will also provide you with the opportunity to earn incentives (up to $300 for individual coverage & up to $850 for family coverage) which will be contributed to your HSA. To earn these HSA incentives, you must complete the "Ready! Set! Go!" program (See the current IBM Benefits Enrollment Guide for Active Employees for more details on this program).

Your Contributions: Subject to the annual limits described above, individuals who open an HSA may make their own HSA contributions in addition to any contributions or incentives made by IBM.

The HSA contribution limit includes and is calculated on both the participant and employer (IBM) contributions. Individuals can elect to make HSA contributions through automatic payroll deductions (on a pretax basis) or through direct payment to the HSA trustee by personal check (on a post-tax basis). You can make pretax contributions to your HSA via IBM payroll if you satisfy each of the following requirements:

- you must be enrolled in an IBM HSA-eligible health plan option,
- you must have opened an HSA account with the IBM designated trustee, and
- you must be on IBM's active payroll.

Note: *IBM contributions (including those earned from Live Well. Live Better. Rewards Program) and employee contributions will not be partially contributed to your HSA account. Any contributions that carry you over the IRS limit may be rejected by the HSA Administrator (Fidelity) and will not be made to your account.*

2019 Total Eligible Contributions

	Individual HSA election	Family HSA election
Maximum Payroll Deduction	$2,700	$5,400
Total IBM Contributions (made of up of the following)	$800	$1,600
IBM Contribution	$250	$500
Jump Start Contribution	$250	$250
Health Incentives	$300	$850
Total Contributions*	**$3,500**	**$7,000**

Please note: IBM reduces the maximum payroll deduction to account for IBM contributions, the Jump Start contributions, and the Health Incentives. For 2019, the maximum payroll deduction you can make is $5,400 for an HSA with family election and $2,700 for an individual HSA election. This allows you to contribute the maximum possible contribution with the least out-of-pocket dollars. The chart above shows how IBM contributions help reduce the amount you have to contribute.

Catch Up HSA Contributions

If you are age 55 or older, you can contribute up to $1,000 "catch-up" contributions (above the IRS limit of $3,500 for individuals and $7,000 for families). Catch-up contributions can be made directly by you to your Fidelity HSA account or by using payroll deductions. If you choose not to use payroll deductions, you can make contributions directly to your Fidelity HSA by doing the following:

- Make your check out to Fidelity Brokerage Services LLC.
- Include your account number and the contribution year to which it should be applied.
- Mail your check, along with a deposit slip, to:

  Fidelity Investments
  PO Box 770001
  Cincinnati, OH 45277-000

Be sure to include a deposit slip for efficient processing. If you do not already have a deposit slip for your HSA, you can print a generic deposit slip or request preprinted deposit slips with your account number from Fidelity.com.

If you have questions, please call the IBM Benefits Center at 866-937-0720 (TTY: 800-426-6537). IBM Benefits Center – Provided by Fidelity representatives are available Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m. Eastern time.

Reimbursements from the HSA

There are multiple ways to use your HSA for payment or reimbursement of qualified medical expenses, including:

- Fidelity HSA debit card.
- Fidelity BillPay® for Health Savings Accounts.
- Fidelity HSA checkbook.
- Pay out of pocket.

You can take the money out of your HSA anytime, tax-free and without penalty, to pay for qualified medical expenses. If you withdraw funds for other purposes before you are age 65, you'll pay income taxes on the withdrawal plus a 20% penalty.

Note: While all HSA deposits and earnings are free from federal taxes, state and/or local taxes may apply. ***You are solely responsible for understanding and following tax rules. Because these rules are complex, we urge you to contact a tax advisor or your HSA trustee for more specific information, or if you have any questions about your particular situation.***

IBM PPO with HSA, IBM Enhanced PPO with HSA Coverage Summary

The following chart shows what you pay under IBM PPO with HSA, and IBM Enhanced PPO with HSA for covered services after you meet any applicable annual deductibles. There is generally no coverage for medical services received outside the network, except in emergencies and certain other circumstances. See "Out-of-Network Medical Coverage," for more information.

If you obtain out-of-network mental health and substance use care, you will be responsible for any amounts that exceed 80% of the U&P rate and these amounts are not applied to the annual deductible or the annual out-of-pocket maximum.

Note:

- *Prescription drugs are provided directly through the IBM Managed Pharmacy Program. Prescription drugs are subject to the deductibles, except for preventive drugs, which are not subject to the deductible.*
- *Mental health/substance use services are provided through the IBM Managed Mental Health Care Program and are subject to the deductibles.*

	IBM PPO with HSA (In-Network)	IBM Enhanced PPO with HSA (In-Network)
Service		
Medical (You Pay)		
Routine Preventive Care	0%, no deductible	0%, no deductible
Primary Care Physician	0%, after deductible for office visits	0%, after deductible for office visits
Maternity Care	0%, no deductible, pre/post-natal visits	0%, no deductible, pre/post-natal visits
Specialty Care Physician/Other Provider	25%, after deductible including office visit, Urgent Care clinics and inpatient services	25%, after deductible including office visit, Urgent Care clinics and inpatient services
Labs	30%, after deductible	30%, after deductible
X-ray	30%, after deductible	30%, after deductible
High Cost Imaging - CAT Scan/PET Scan/MRI	30%, after deductible; precertification required[2]	30%, after deductible; precertification required[2]
Medical Supplies/Durable Medical Equipment	Inpatient: 25%, after deductible Outpatient: 30%, after deductible	Inpatient: 25%, after deductible Outpatient: 30%, after deductible
Inpatient Hospitalization	25%, after deductible, including professional charges[1]	25%, after deductible, including professional charges[1]
Outpatient Services (Surgical and Non-Surgical)*	Facility charges: 30%, after deductible Professional charges: No charge PCP, after deductible/30% SCP, after deductible[1]	Facility charges: 30%, after deductible Professional charges: No charge PCP, after deductible/30% SCP, after deductible[1]

	IBM PPO with HSA (In-Network)	IBM Enhanced PPO with HSA (In-Network)
Emergency Room	30%, after deductible, PLUS $150 copay (copay waived if admitted) Physician Fees: 30%, after deductible	30%, after deductible, PLUS $150 copay (copay waived if admitted) Physician Fees: 30%, after deductible

[1]Transplant, bariatric, infertility and orthopedic services must be received at a Center of Excellence (COE) to receive the highest benefit level. Contact your Plan Administrator for more information.

[2]Precertification is required for non-emergency high cost diagnostic services such as CT scans, MRIs, PET scans, sleep studies, and cardiac studies for the IBM plan to pay a benefit.

*All charges associated with surgical procedures performed in a physician's office are reimbursed at the physician's office visit coinsurance rate.

ANNUAL DEDUCTIBLE

The annual deductibles for the IBM PPO with HSA and IBM Enhanced PPO with HSA work differently than under the other IBM PPO options. Here's how the annual deductible under these options works:

- Prescription drugs (excluding preventive drugs) and mental health/substance use services are subject to the plan deductible.
- In all situations involving the enrollment of one or more dependents, the entire family deductible must be met before benefits are paid for any individual family member.
- The annual deductible also counts toward the annual out-of-pocket maximum.

The annual deductible *does not* apply to eligible routine preventive services or preventive drugs (refer the appropriate sections in this document for details about the IBM PPO with HSA, and IBM Enhanced PPO with HSA Preventive Drug Benefit).

Individual Deductible (applies only to participant enrolled in self-only coverage)

Once you meet the individual annual deductible, the Plan will pay the applicable percentage of eligible expenses, based on the negotiated rate or provider's actual charge, depending on the type of service.

Family Deductible (applies to participant enrolled with one or more family members)

As soon as the family members (individually or combined) have met the family deductible, the Plan will pay the applicable percentage of eligible expenses, based on the negotiated rate or the provider's actual charge, depending on the type of service. If one individual meets the individual deductible but the family deductible is not yet met, benefits *will not* be paid to that individual (or to the other family members) until the family deductible is satisfied.

ANNUAL OUT-OF-POCKET MAXIMUM

The IBM PPO with HSA and IBM Enhanced PPO with HSA limits how much you and your covered family members have to pay out of your own pocket each year for eligible medical expenses (including pharmacy and mental health/substance use). This is known as your annual out-of-pocket maximum. Once you reach the individual out-of-pocket maximum, the Plan will pay 100% of the negotiated fee or the provider's actual charge for any additional eligible expenses for the remainder of the plan year.

Once an individual meets the individual out-of-pocket maximum or the family meets the family out-of-pocket maximum, the Plan will pay 100% of eligible expenses for all covered individuals, even if they have not met their individual out-of-pocket maximum.

Care Management Program

Each of the medical plan administrators have a Care Management Program, comprised of Care Coordination and Chronic Condition Management, which provides targeted outreach by registered nurses who will provide assistance and support to participants with general health concerns, chronic medical conditions and complex medical issues.

CARE MANAGEMENT

Care Management is a voluntary service available to non-Medicare-eligible participants enrolled in the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA.

Care Management is performed by registered nurses (called Care Coordinators) and designed to assist you and your enrolled family members. It is not the Care Coordinator's role to recommend specific physicians but rather to provide general medical information.

A Care Coordinator may contact your physician to obtain additional information regarding your condition. The Care Coordinator confirms if hospital stays are medically necessary and the proposed treatment is medically necessary for the diagnosis. They will also review opportunities for treatment to be received in a more cost-effective setting. A Care Coordinator will confirm the number of inpatient days for your specific medical condition with your physician and review your physician's treatment plan for medical necessity and appropriateness. The Care Coordinator will then follow up with your physician and/or hospital regarding your condition before discharge to determine if additional days are necessary and to help ensure that plans are made for your post-hospital care (if appropriate). The Care Coordinator may also provide information about other treatment alternatives that are available. They can also assist in helping you understand your medical condition and the level of care you and your non-Medicare-eligible dependents need.

Care Coordination includes the following features for medical care rendered in the United States:

- Coordination of medical treatment and assistance in arranging necessary medical resources.
- Support and information on up-to-date treatment programs and medical technology.
- Assistance with catastrophic medical conditions and situations such as cancer, traumatic head and spinal injuries and extensive burns.
- Guidance and care coordination involving a need for skilled medical care, including referrals to nationwide specialty centers for bariatric surgery, infertility services, orthopedic surgeries (such as hip and knee replacement) and transplants. These facilities are among the most prominent in their field and offer sophisticated medical technology.
- Establishment of appropriate medical follow-up care.
- Health promotion.
- Monitoring of participants understanding of their medical condition and treatment plan.
- Educational materials.
- Hospital discharge planning.
- Complex skilled home health care assessments.
- Education on available services through Best Doctors.

Based upon the level of severity of the condition, ongoing telephone contact will be scheduled with a Care Coordinator. Participants may also contact the health plan administrator's Care Coordinator directly

to request assistance. In some instances (skilled nursing facility admissions, rehabilitation facility admissions; bariatric surgery, infertility services, orthopedic surgeries (such as hip and knee replacement) and organ transplants, skilled home health care), participation in Care Coordination is required.

Voluntary Nurse Helpline

The Voluntary Helpline provides you with an opportunity to talk to a registered nurse who can provide timely health information on a wide variety of topics to help you make informed and appropriate decisions. It is available 24 hours a day, 7 days a week, within the United States.

Examples of the support available include:

- Suggestions for self-care
- Information on prevention of disease
- Discussion about symptoms and courses of treatment
- Personalized education about new, ongoing or recurring health problems
- Questions to ask your physician
- Pediatric health questions
- Geriatric health care issues
- Information about diagnostic tests such as MRIs and CAT scans.

Care Coordination for Transplants

Guidance and care coordination include referrals to nationwide specialty centers for transplants and establishment of appropriate medical follow-up care. These facilities offer sophisticated medical technology and have established financially advantageous contracted agreements.

For certain services such as a transplant, you *must* use one of the hospitals specified as a transplant Center of Excellence (COE) facility. If you use any other facility, even one that participates in the health plan's overall network, a lower level of benefits or no benefits will be paid under the IBM PPO, IBM PPO Plus, IBM PPO with HSA, and IBM Enhanced PPO with HSA options. If you are enrolled in the IBM EPO plan and do not use a COE, you will have no medical coverage for the procedure. Please call your health plan administrator for additional information.

Note: In some cases a transplant unit within a network hospital facility may not be part of the facility and may bill for services separately. You are strongly urged to contact the health plan administrator to ensure the transplant unit is approved and a network provider so you will have a clear understanding of the benefits before seeking services.

When medical precertification has been obtained from the specialty center under this program and as specified by the health plan administrator under this program, lodging (up to $50 a day) and travel expenses, if more than a 50-mile drive for the patient and one family member, may be eligible for reimbursement in accordance with established guidelines. In order for the benefit to be payable, members must utilize a Center of Excellence facility. Unreimbursed expenses will not apply toward the out-of-pocket maximum. The health plan's Care Coordinator reviews the physician's treatment plan for medical necessity and appropriateness and provides authorization for claims submitted for certain items and services to the health plan administering the IBM Medical Plans.

In order to perform Care Coordination services, it is necessary for the health plan administrator's Care Coordinators to receive medical information about the patient from the patient's health care providers. The patient or an authorized representative of the patient may therefore be required to provide written consent to release medical information.

Centers of Excellence for Bariatric, Infertility, Orthopedic and Spine Services
IBM's health plan administrators have Centers of Excellence (COEs), facilities and providers that meet certain quality standards of care. In general, these providers' outcomes are better than others. Any member seeking care for the following surgeries or procedures must use a COE for the highest level of coverage.

These services include:

- Infertility services, including, but not limited to, artificial insemination or in vitro fertilization (enrollment in a care management program also is required.)
- Orthopedic and spine surgery, including, but not limited to, knee or hip replacement or spinal fusion
- Bariatric surgery

You may qualify for travel and lodging benefits related to orthopedic and bariatric services.

If you choose not to use a COE or enroll in the required program, your benefit for using an in-network, non-COE provider will be the following:

- Infertility and bariatric:
  - IBM EPO: No coverage
  - IBM PPO options: You will pay 45% of the negotiated cost for in-network non-COE providers.
- Orthopedic surgery: You pay an additional 10% of the negotiated cost for your plan option

Please call your health plan administrator before seeking any of these types of services.

When medical precertification has been obtained for a bariatric or orthopedic COE, lodging and travel expenses (up to $50 a day), if more than a 50-mile drive for the patient and one family member, may be eligible for reimbursement in accordance with established guidelines. In order for the benefit to be payable, members must utilize an in-network Center of Excellence facility. Unreimbursed expenses will not apply toward the out-of-pocket maximum. The health plan's Care Coordinator reviews the physician's treatment plan for medical necessity and appropriateness and provides authorization for claims submitted for certain items and services to the health plan administering the IBM Medical Plans.

Extraordinary Coverage
In certain circumstances, the health plan administrators are authorized to approve coverage under the IBM Plan for charges not generally covered. These may include charges in life-or-death situations, for treatments as a last resort, for treatments which are not otherwise eligible or charges for a greater quantity of services or treatments than would otherwise be covered.

In no event, however, is there authorization to approve coverage for care which is primarily custodial in nature. And, in no event, is authorization provided to approve lifetime benefits beyond the maximum per family for medical, mental health/substance use or pharmacy benefit payments.

Approvals for extraordinary coverage are given only on a case-by-case basis. A case must be managed by a Care Coordinator and be in case management in order to be considered for such an approval. The same reimbursement rates which apply to services that are similar but are generally covered under a plan will apply to charges for which extraordinary coverage under a plan is approved; this works within the IBM Plan and does not provide additional financial assistance. Approval of extraordinary coverage must be

obtained before the charges are incurred, otherwise such coverage will not be available, and benefits will not be payable.

Referrals from Other Health Plan Administrators

Cases may also be brought to the Care Coordinator's attention by other administrators, such as, CVS Caremark and Optum, as a result of information obtained during normal medical utilization reviews. In order for the Care Coordinator to complete an assessment of the situation, your attending physician may be contacted to review the medical details of the case. If it is determined that the program would be helpful, the individual will be offered this voluntary service.

Memorial Sloan Kettering Cancer Center (MSK)

If you're facing a cancer diagnosis, you can access certain services provided by the Memorial Sloan Kettering Cancer Center (MSK), including access to second opinions, local referrals, oncologist access to Watson for Oncology, and more.

MSK Direct is offered to IBMers, retirees and extended family members, including but not limited to your spouse or domestic partner, children, parents, grandparents, siblings, aunts/uncles, cousins, nieces/nephews and in-laws. Services include:

- **MSK Direct guided access**. IBMers, retirees and extended family members worldwide can get an in-person appointment at one of MSK's New York or New Jersey facilities to meet with an oncologist and dedicated team of cancer specialists within two business days of the initial phone call.[1]
- **Remote second opinions/local referrals**. The ability to receive a remote second opinion or a referral to a cancer treatment facility closer to you if you cannot travel to MSK's facilities for in-person care.
- **Oncologist access to Watson for Oncology** trained by Memorial Sloan Kettering. If determined appropriate by MSK, a Watson for Oncology review may be included in the information considered by the MSK oncologist before receiving your treatment plan or remote second opinion report from MSK. Watson for Oncology is not a stand-alone offering and can only be used in conjunction with an in-person appointment or remote second opinion.[2]

The MSK hospital location is on the Upper East Side of Manhattan, New York. The state-of-the-art outpatient facilities are in New York City (Manhattan, Brooklyn), Long Island, Westchester and New Jersey.

To request an appointment or to contact the MSK Direct Care Advisors, call 844-350-5032, Monday through Friday, between 8:30 a.m. to 5:30 p.m. Eastern time. Messages left outside of these hours will be returned the next business day.

[1] Subject to availability of your medical records, your ability to travel to MSK, clinical considerations, and health insurance coverage for care at MSK. Watson for Oncology may not be available in every jurisdiction.

[2] A Watson for Oncology report may only be generated for certain cancers. As of 2018, Watson supports: breast, lung, cervical, prostate, ovarian, colon, rectal and gastric (list of supported cancers are being added; check with MSK for details). Availability of Watson for Oncology is also subject to a confirmed diagnosis and adequate information available within a patient's medical records prior to an in-person appointment. The MSK Direct program does not guarantee any patient's access to Watson for Oncology or that it will be provided without cost. MSK will determine if a report can be run and if it is clinically appropriate for each individual patient. Access to and use of Watson for Oncology is subject to all conditions and restrictions of each patient's health insurer, if any.

CHRONIC CONDITION MANAGEMENT PROGRAM

The IBM Chronic Condition Management Program, administered by the health plan administrators and Optum (Depression Only), is available to employees and their dependents (non-Medicare-eligible) who are enrolled in an IBM Medical Plan.

Condition Management provides targeted outreach and one-on-one medical support, education and assistance to eligible members with specified chronic medical conditions. Members learn specific techniques to prevent the worsening of their medical condition. This program is completely voluntary. Condition Management is provided by IBM dedicated Care Managers who are specifically-trained Registered Nurses or licensed Masters-level clinicians (Depression only).

Covered Conditions

Each condition has specific evidence-based clinical guidelines which support the care plan. Condition Management covers the following chronic illnesses:

- Asthma
- Congestive Heart Failure
- Coronary Artery Disease
- Depression
- Diabetes
- Musculoskeletal pain

Program Components

The health plan administrator and Optum Care Managers will provide you with individual support that includes goal setting, lifestyle coaching and the following condition specific interventions:

- Health risk assessments and risk stratification conducted to help you evaluate your health status. You and your doctor will receive an individualized summary report of the risk assessment.
- Medical information regarding condition specific interventions.
- Consultation regarding clinical statistics and lab results.
- Monitoring and support for adherence to ongoing clinical goals.
- Periodic telephone consultations (a Care Manager will call you at scheduled intervals to review your health status).
- Educational materials based on the information you provide about your medical condition during the phone consultations which is specific to your needs.
- Information about a particular health care topic at any time, including special adolescent and pediatric materials.
- Access to condition management information at the administrator's web site.
- Access to Optum's web site at www.liveandworkwell.com.

Proactive Provider Interventions

Your treating physician will be notified that you have been offered Condition Management services. The information will contain details regarding Condition Management and how it works. Your treating physician receives copies of all health-related assessments. Based on the need, the Care Manager will facilitate the proper level of interaction with the treating physician's office.

Your treating physician will also receive copies of Condition Management clinical practice recommendations and guidelines. Physicians will be encouraged to review these materials to avoid a

conflict in the treatment care plan. Should a conflict arise, the Care Manager will instruct you to discuss the issue with your treating physician directly. In addition, the Care Manager will notify your physician of any clinical conflicts identified during interactions with the patient.

Information and Support Line
You can call the toll-free Information and Support Line — 24 hours a day, 365 days per year — to talk to a Registered Nurse about your condition, depending on the nature of your inquiry.

Confidentiality
The health plan administrator maintains the confidentiality of all patient-specific clinical information received from patients, their family members and their health care providers. Confidential information will not be disclosed to IBM or others without your express written consent except when required by law, or (subject to applicable law) to a third party contracted by the Plan to review the program practices, including its clinical records, to evaluate the program administrator.

Following IBM's strict employee health privacy and confidentiality guidelines and subject to applicable law, our health benefits vendors will share data with each other to help identify individuals who will be specifically and overtly contacted by a health benefits vendor(s) and ask them to participate in certain programs, specific to their medical conditions, like disease management programs. These services are provided as a voluntary benefit, providing intervention and educational strategies to help those with chronic illness. Data sharing among the health benefits vendor(s) is conducted in accordance with the IBM Plan's strict medical privacy and confidentiality guidelines and will remain confidential and will not be shared outside the administration of the Plan.

What's Covered Under the Medical Plan Options

MEDICAL NECESSITY

All treatments, services or supplies must be medically necessary and appropriate for the condition being treated, as determined by or on behalf of the plan administrator. Except where state law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean those health care services rendered in accordance with generally-accepted standards of practice in the medical or dental professions, that are:

- Required to diagnose or treat an illness, injury, disease or its symptoms.
- Considered effective for the patient's medical condition, illness, injury or disease.
- Clinically appropriate, in terms of type, frequency, extent, site and duration.
- Not primarily for the convenience of the patient, patient's family or healthcare provider, a physician or any other healthcare provider.
- Rendered in the least intensive setting that is appropriate for the safe delivery of the services and supplies.
- Rendered in the most efficient and economical way; not more costly than an alternative service or sequence of services which would produce equivalent therapeutic or diagnostic results beneficial to the diagnosis or treatment of the covered person's illness, injury or disease.
- Based on credible scientifically-based guidelines of national medical, research or governmental agencies.

The fact that a physician or medical professional has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness does not mean it is a medically necessary covered health service under the IBM Plan.

ELIGIBLE PRACTITIONERS AND FACILITIES

- "Acupuncturist" — A person licensed as such by the state in which he or she practices.
- "Ambulatory Surgical Center" — A facility in which minor surgery is performed and the patient is released the same day. Facilities must meet the health plan's accreditation criteria. Prior review of accreditation criteria with the health plan is advised to ensure coverage.
- "Birthing Center" — An alternative facility for women with low-risk pregnancies who do not wish a hospital confinement. Facilities must meet the health plan's accreditation criteria. Prior review of accreditation criteria with the health plan is advised to ensure coverage.
- "Certified Registered Nurse Anesthetist" (CRNA) — A person licensed as such by the state in which he or she practices in the administration of general anesthesia services.
- "Certified Nurse Midwife" — A practitioner certified as a nurse-midwife by the state in which he or she practices and is licensed by such state to perform obstetrical services within the scope of practice.
- "Chiropractor" — A person licensed as such by the state in which he or she practices.
- "Christian Science Practitioner" and "Christian Science Nurse" — A person certified as such by the Christian Science Mother Church in Boston, Massachusetts. *Note: All mental health coverage must meet the criteria of eligible providers under the IBM Managed Mental Health Program.*
- "Dentist" — A person licensed as such by the state in which he or she practices.
- "Extended Care (Skilled Nursing) Facility" — An extended care facility must meet one or more of the following requirements to be eligible for coverage: approval by Medicare; approval by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); acceptance by the health plan under criteria it adopts to carry out the intent of hospital services.

  Note: Nursing homes, assisted living, convalescent homes and care which are primarily custodial are not eligible for coverage.
- "Hospice" — Hospice care is a program of comprehensive services provided to the terminally ill. While medical care is one component, the emphasis is placed on making the person comfortable, both physically and mentally, in his or her last days. The care can be rendered either in a hospice facility or at home. Although the principal intent is to help terminal patients cope with illness while in the home, the agency will arrange, when necessary, for admission to an accredited hospice facility.
- "Hospital" — Any institution operating, according to law, to provide for a fee medical, diagnostic and surgical facilities for patients. The hospital must provide supervision by a staff of physicians and 24-hour nursing service by registered graduate nurses.
- Christian Science Sanatoriums are considered eligible for confinements which would require a hospital confinement if treatment were being rendered under the supervision of a physician. Such Sanatoriums must be certified by The Commission for Accreditation of Christian Science Nursing Organizations/ Facilities, Inc.
- "Licensed Nutritionist" - A person licensed by the American Clinical Board of Nutritionists and the state in which he/she provides general nutrition services.
- "Nurse" — A registered nurse (RN), licensed practical nurse (LPN), Christian Science nurse or other registered graduate nurse.

- "Nurse Practitioner" — A person licensed as such by the state in which he or she practices and who is employed and supervised by a licensed physician as defined by the IBM Plan. Physician assistants and nurse practitioners are considered PCPs as long as they are employed and supervised by a licensed physician and submit charges through a PCP.
- "Occupational Therapist" — A person licensed/certified as such by the state in which he or she practices, or a person who is certified as such by the American Occupational Therapy Association.
- "Physical Therapist" — A certified physiotherapist.
- "Physician" — A person licensed by the state in which he or she is practices medicine and performs surgery.
- "Primary Care Physician" (PCP) — A physician (MD or DO) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, pediatric medicine; or, physician assistant or nurse practitioner, who provides care in an outpatient setting that promotes ongoing care such as an office, outpatient surgery, retail walk-in clinic, nursing facility or home.

  Note: Physician services rendered in an urgent care facility or inpatient setting are not considered PCP services.
- "Physician Assistant" — A person licensed by the state in which he or she practices and who is employed and supervised by a licensed physician as defined by the IBM Plan. Physician assistants and nurse practitioners are considered PCPs as long as they are employed and supervised by a licensed physician and submit charges through a PCP.
- "Registered Dietician" — A person licensed by the state in which he or she practices by the Commission of Dietetic Registration (CDR). See "Nutritional Counseling" in "What's Covered Under the IBM Medical Plan" for coverage information.
- "Speech-Language Pathologist or Audiologist" — A person who (1) holds a certificate of clinical competence in speech-language pathology or audiology from the American Speech-Language-Hearing Association and/or (2) is licensed by the state in which he or she practices to provide speech-language pathology or audiology.

In addition to the above list of eligible providers, services received from other classifications of providers are eligible for coverage when the provider is licensed to provide those services and the provider is participating in the health plan's network.

COVERED SERVICES

The Plan covers medical services deemed necessary in the diagnosis and treatment of injury, illness and/or pregnancy, as well as certain preventive care services, when rendered by eligible providers. Specific covered services are listed in the sections that follow.

Accidental Injury to Sound Natural Teeth

Treatment for accidental injury to sound natural teeth is covered under the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA provided the services are rendered within one year of the date of the accident. Treatment for accidental injury to sound natural teeth is covered if services have commenced within one year of the date of the accident. The purpose of this coverage is to permit the restoration of function to the accidentally-injured sound and natural teeth. Treatment must be medically necessary as determined by the health plan administrator and a continuous course of dental treatment for care resulting from and directly related to the accident.

Note: An "accidental injury" is defined as an injury caused by external force or through abnormal force exerted by a hard, sometimes foreign, object in the mouth. In neither case can the injury be brought about as part of the prevention or treatment of a health problem.

Acupuncture
Acupuncture is covered when rendered for treatment of an eligible medical condition and *only* by a licensed provider. Acupuncture services for routine preventive care and maintenance are *not* eligible for reimbursement.

Ambulance Service (Air or Ground)
Eligible ambulance services will be considered at the in-network level and are covered only:

- When it is medically required emergency transportation to the closest hospital with necessary medical facilities for care
- When it is medically required transportation from an out-of-network hospital to an in-network hospital, as determined by the health plan or
- When it involves transportation from an out-of-network hospital to an in-network hospital for mental health/substance use treatment, as determined and recommended by the mental health care Plan Administrator.

Ambulance service from the hospital to your home, rehabilitation center, nursing home, skilled nursing facility, residential treatment center or other step-down care facility or for non-emergency situations will only be covered where considered medically necessary and with the prior approval from the health plan administrators.

Anesthesiology and Surgery
Anesthesiology and surgery are eligible when performed by a physician in a hospital (inpatient or outpatient), clinic, ambulatory surgical facility, birthing center or at home. Surgical procedures performed as part of an office visit will be subject to the surgical charge and not considered separately. Services provided by a physician acting as an assistant surgeon in complex procedures may also be eligible if determined to be medically necessary by the health plan.

Except in certain cases involving accidental injury (see "Accidental Injury to Sound Natural Teeth," above), charges for oral surgery are not eligible for benefits under the IBM medical plan options but may be eligible under the applicable dental plan option (see the Dental Coverage section for information).

Assistant Surgeons
Assistant surgeons' fees are eligible only for complex surgical procedures where their services are determined to be medically necessary. Since there are limited circumstances where the services of an assistant surgeon are considered medically necessary, you are urged, before scheduled surgery, to contact the health plan for a predetermination. You should discuss with your surgeon whether or not assistant surgeons will be used and understand what you will be reimbursed.

Where an assistant is medically necessary, physician services are eligible. Services of nurses or other non-physician personnel practicing independently are not eligible for coverage.

Chemotherapy/Radiation Treatment
Chemotherapy and radiation therapy are eligible when they are provided and billed by a physician or an eligible facility. To be eligible for coverage, the following criteria must be met:

- Treatment must be rendered by the attending physician (e.g., treating oncologist/radiologist) responsible for the overall treatment plan.

- Laboratory and x-ray services necessary for the preparation or administration of the treatment protocol which are ordered by the attending physician.
- Chemotherapy drugs and certain supplies must have FDA approval as chemotherapy agents and be prescribed by the attending physician. When purchased at a pharmacy for outpatient use, the drugs and certain supplies will be covered under the IBM Managed Pharmacy Program.

CVS SPECIALTY PHARMACY

If you need covered prescription medications which require special handling or administration, like chemotherapy, and are currently receiving these medications through your doctor's office or other treatment center, you may want to consider ordering them through the CVS Specialty Pharmacy, part of the IBM Managed Pharmacy Program. By receiving covered prescription medications this way, you may pay less for them overall. Additionally, you may be able to have them shipped directly to you or your doctor's office at no additional charge. Contact CVS Caremark Customer Care for more details.

Chiropractic Care

Chiropractic care rendered by a licensed provider in the treatment of a medical condition is covered, subject to determination of medical necessity. Chiropractic treatment is limited to no more than 40 visits annually per individual. Routine preventive care, spinal subluxation and maintenance are not eligible for reimbursement.

Contraceptive Devices

Contraceptive devices and implants are eligible for coverage. Prescribed contraceptive drugs, devices or implants methods are covered in full and are not subject to the deductible or coinsurance. Contraceptive procedures (such as sterilization) will be covered medical services subject to applicable deductibles and coinsurance of the plan option.

Cosmetic Surgery

Cosmetic surgery is eligible for children under the age of 13 if the surgery is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from accident or trauma or a disfiguring disease. Cosmetic surgery for patients over the age of 13 is eligible only when the surgery is necessary to correct a functional and/or physical disability resulting from deformity at birth or a condition arising as a result of accidental injury. The surgery must begin within six months of the accident unless it is not medically advisable to do so. Other cosmetic surgery is not eligible.

Emergency Treatment

Coverage for emergency room visits for medical emergencies as a result of a sudden and serious illness or accidental injury is covered. An emergency is the sudden onset of an acute medical condition that, without immediate medical care, could result in serious harm to your health, bodily functions or body parts (for example, sudden shortness of breath, uncontrolled bleeding, sudden severe intractable pain or any sudden onset of symptoms or illness a reasonable person would consider an emergency). Emergencies are covered by the IBM Plan at the in-network benefit level.

Extended Care (Skilled Nursing) Facilities

Extended care (skilled nursing) facilities may be eligible up to a maximum of 30 days per admission. This 30-day benefit may be extended based on medical necessity as determined by a Care Coordinator's review for medical necessity. Eligible expenses include charges for room and board at the semi-private room rate, skilled nursing, physical therapy, drugs and medical supplies.

To be eligible, the patient must require full-time nursing or skilled rehabilitative services, as certified by the patient's physician in writing. Precertification is required for benefits to be eligible. Care Coordinators are required to perform a medical review and obtain medical information from your treating physician

for skilled nursing facility admissions to determine if the services requested are eligible for coverage. Claims received for skilled nursing facility admissions that have not been authorized will be denied. See "Precertification" earlier in this section for more information.

Note: Nursing homes, assisted living, convalescent homes and care which are primarily custodial are not eligible for coverage. Custodial care or care received in these facilities may be covered under the Long-Term Care Insurance Program for enrolled participants. For more details regarding the Long-Term Care Insurance Program About Your Benefits: Income and Asset Protection on w3 under "Legal Notices" for a description of covered services, eligibility requirements and enrollment procedures.

Treatment of Gender Dysphoria and Gender Nonconformity

Certain surgeries and therapies provided as treatment of gender dysphoria are eligible for coverage. Eligible services include:

- Hormone therapy to feminize or masculinize the body as desired
- Laboratory testing to monitor the safety of continuous hormone therapy
- Psychotherapy for gender dysphoria, including individual, couple, family, or group
- Voice therapy/Voice lessons
- Surgical procedures for the Male-to-Female (MtF) Patient:
  - Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);
  - Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;
  - Nongenital, nonbreast surgical interventions: facial feminization surgery, liposuction, lipofilling, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction,
  - Various aesthetic procedures:
    - Thyroid chondroplasty (reduction in size of thyroid cartilage);
    - Facial feminization surgery, including but not limited to: facial bone reduction, face "lift," facial hair removal, and certain facial plastic reconstruction.
- Surgical Procedures for the Female-to-Male (FtM) Patient:
  - Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;
  - Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty and implantation of erection and/or testicular prostheses; and
  - Nongenital, nonbreast surgical interventions: liposuction, lipofilling, pectoral implants.
  - Various aesthetic procedures.
- Rhinoplasty
- Blepharoplasty

Most services and procedures are subject to prior authorization. The patient is strongly encouraged to work with a Care Coordinator (see the "Care Management" section for more information).

Hormone Therapy
The patient must meet all of the following eligibility qualifications for hormone therapy (in addition to the overall eligibility requirements under "Eligibility" in the About the IBM Personal Benefits Program section). For adults, the patient must:

- Show persistent, well-documented gender dysphoria;
- Have the capacity to make a fully informed decision and to consent for treatment; demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks; and
- Be age 18 years or older (age of majority may vary by country). Adolescents under the age of 18 may be eligible to begin feminizing/masculinizing hormone therapy, with parental consent. Treatment decisions should be made among the adolescent, the family and the treatment team.

If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormones should not be denied solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C

For adolescents, the patient must meet minimum criteria to qualify for puberty-suppressing hormones therapy. These include:

- Demonstrating a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
- Gender dysphoria that emerged or worsened with the onset of puberty;
- Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the patient's situation and functioning are stable enough to start treatment;
- The patient has given informed consent and the parents or other caretakers or guardians have consented to the treatment and are supporting the patient throughout the treatment process.

Adolescents may be eligible for puberty-suppressing hormones as soon as pubertal changes have reached Tanner stage 2. Covered medications include

- GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty.
- Progestins (most commonly medroxyprogesterone)
- Other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues and
- Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

Coverage should include physician visits and laboratory testing to monitor the safety of continuous hormone therapy.

Surgery
All of the following eligibility qualifications for genital surgery and surgery to change secondary sex characteristics (in addition to the overall eligibility requirements described under "Eligibility" in the About the IBM Personal Benefits Program section) must be met:

- Surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender dysphoria;

- The treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards;
- The patient must be 18 years or older; chest surgery may be performed at an earlier age and preferably after ample time of living in the desired gender role and after completion of one full year of hormone therapy (this is intended to give the adolescent ample opportunity to experience and socially adjust in the desired gender role before undergoing irreversible surgery);
- The patient must have completed 12 months of continuous hormone therapy for those without contraindications (required for genital surgery only);
- The patient must have completed 12 months of successful continuous full-time real-life experience in the desired gender (required for genital surgery only);
- If significant medical or mental health concerns are present, they must be reasonably well controlled; and
- The Physician who is performing the surgery must notify the health plan before performing the surgery.

Exclusions
In addition to general exclusions see ("Exclusions: What the IBM Medical Plan Does Not Cover") the following expenses are specifically excluded with respect to treatment of gender dysphoria

- Care received outside the United States
- Travel and lodging expenses for care received away from home
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;
- Sperm preservation in advance of hormone treatment or gender surgery;
- Cryopreservation of fertilized embryos; and
- Infertility

Hearing Care
Cochlear implants and post-cochlear implant aural therapy are eligible for coverage. Hearing aids and devices prescribed by a physician or licensed audiologist for the correction of hearing deficiencies are covered.

For children up to the age of six, the IBM Plan will cover the first set of hearing aids at 100% after the annual deductible is satisfied (there is no maximum reimbursement and copays and coinsurance do not apply). Any additional sets of hearing aids (up to the age of 6) will be covered subject to the annual deductible, coinsurance and copays. Maximum reimbursement is $2,000 ($1,000 per ear). For all other patients, the maximum reimbursement is $1,500 ($750 per ear) for each individual per year for hearing devices, including repairs and batteries. If you are enrolled in an HMO, review the summary benefit description of the HMO to understand how hearing aids are covered.

Home Dialysis
Under Social Security Administration regulations, you or your eligible dependents undergoing treatment for permanent kidney failure become eligible for Medicare coverage of home dialysis, regardless of age, after undergoing home dialysis treatment for a certain period of time. Contact your local Social Security Office for information on this Medicare coverage.

Until the patient becomes eligible for Medicare coverage, home dialysis treatment for kidney failure is eligible under the Plan. Once Medicare becomes the primary coverage, the Plan will provide secondary benefits coverage (see "Coordinating IBM Medical Coverage with Medicare" in the Administrative Information section for more details).

Home Health Care

Before arranging for skilled home health care or outpatient nursing services, you must contact your health plan administrator to determine if the services are eligible for coverage. If they are determined to be eligible, the health plan administrator will work with your physician to provide home health care by arranging for the prescribed services and supplies. The health plan administrator is required to perform a skilled home health care review and obtain medical information from your physician in order to determine if the services requested are eligible for coverage. This review is intended to ensure that the skilled home health care services are medically necessary and appropriate for the medical condition.

Only skilled home health care services are eligible for coverage. In such cases, IBM will allow assignment of these benefits directly to the provider of service and you will receive a copy of the Explanation of Benefits (EOB) statement to allow you to verify the charges and reimbursement amount. Any discrepancies should be reported to the health plan administrator immediately.

Claims received for home health care services that have not been authorized will be denied. A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the home health services are subsequently determined not to be eligible under the terms of the IBM Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed not medically necessary. Only skilled home health care services approved by the health plan administrator are medically necessary and meet criteria are eligible for benefits consideration.

Eligible services include:

- Laboratory services
- Medical supplies
- Medications as part of infusion therapy under case management
- Part-time skilled home health nursing care services provided by a licensed nursing agency (nonagency nurses are not eligible for coverage)
- Prescription medicines (other than maintenance type medications routinely prescribed by the physician) and
- Speech, occupational, physical and respiratory therapy.

The following may be eligible under the normal provisions of the IBM Plan:

- Physician visits and
- Skilled follow-up care after hospitalization.

Skilled home health nursing care services consist of those services that must be performed by a registered nurse or licensed practical nurse and meet all of the following criteria for skilled nursing services:

- The service(s) must be ordered by a physician.
- The complexity of the service(s) requires a licensed professional nurse in order to be safely and effectively performed and to achieve the desired medical result.
- The skilled nursing service(s) must be reasonable and necessary for the treatment of the illness or injury, and accepted standards of medical and nursing practice.
- The skilled nursing service(s) is not custodial in nature.

The following home health care services are *not eligible* for coverage under the IBM Plan:

- Care that provides a level of routine maintenance for the purpose of meeting personal needs and which can be provided by a layperson who does not have licensed or professional qualifications, skill or training.
- Homemaking services, such as meal preparation and housecleaning.
- Custodial care, such as but is not limited to, activities of daily living, help in walking, dressing, eating and routine care of a patient.
- Care of colostomy and ileostomy bags and indwelling catheters, gastrostomy tubes and routine tracheotomies.
- Routine dressing changes, cast care and routine care in connection with braces and similar devices.
- Respiratory therapy — gases (including oxygen), routine administration of medical gases after a regimen of therapy has been established.

Home Hemophilia Treatment
Covered treatments include:

- Blood products, plasma and therapeutic blood concentrator or anti-hemophilia factors and
- Home therapy kits, infusion supplies, syringes, needles, etc. required for home care.

Hospitals should be advised to bill the health plan for these fees.

Note: Any portion of the charges paid by government or non-governmental agencies will not be considered for reimbursement.

Hospice Care
Eligibility for hospice care is based on a written statement from the attending physician that the patient's illness is terminal and that further medical care is only supportive in nature. Hospice care which is provided under the direction of a hospice care agency approved by the health plan administrator is eligible for consideration under hospital services up to a maximum of six months. Hospice care beyond six months is subject to medical necessity review and preapproval by the health plan.

Eligible services billed by an approved hospice program include palliative care, medications that require administration by a registered nurse, licensed practical nurse or home health aide (if approved and charged through hospice), physicians and intermittent nursing visits, respiratory equipment and therapy, speech and physical therapy, medical supplies, rental of medical equipment, emotional support services by accredited pastoral counselors and social workers, as well as transportation between the home, hospice facility and hospital as necessary.

Home health care is covered when approved by the health plan administrator, as part of hospice.

Note: Services by volunteers and private duty nursing are ineligible under Hospice Care.

Immunizations/Vaccinations
Immunizations, whether required as the result of an accident or treatment of a medical condition (for example, allergies, rabies) or for prevention (for example, measles, hepatitis, and so on), are covered when the immunization is administered in the doctor's office or another medical facility.

Note: Influenza virus vaccine (flu vaccine)/immunization is covered in-network regardless of the place of service (doctor's office, clinic, local pharmacy/drug store, health department, etc.) if administered by an eligible provider

(nurse, nurse practitioner, physician or pharmacist). For influenza virus vaccine (flu vaccine) administered outside of a doctor's office or another medical facility you must submit with the claim for benefits, the ICD10 or CPT/diagnosis code and signature of who administered the vaccine (nurse, nurse practitioner, physician or pharmacist). See "How to File a Claim" for reimbursement criteria. (Note: For the flu and shingles vaccine only, a licensed pharmacist will be considered an eligible provider.)

Immunizations are excluded from coverage under the IBM Managed Pharmacy Program with the following two exceptions.

- Flu vaccines administered by a retail pharmacist participating in the CVS Caremark vaccine network are covered under the pharmacy benefit.
- The zoster vaccine (shingles vaccine) administered by a retail pharmacist participating in the CVS Caremark vaccine network will be covered under the pharmacy benefit.

Please contact CVS Caremark to check if your pharmacy is in their network.

Inpatient Hospital Services

Coverage under hospital services is for confinement in a hospital or medical care in other eligible facilities. Confinement must be medically necessary and ordered by a physician. If you or a family member is admitted as an inpatient to a hospital while eligible for coverage and coverage changes during that stay (e.g., dependent reaches age 26), all charges otherwise eligible under the Plan which are incurred up until the date of discharge will continue to be eligible for benefits.

Hospital Room

- Includes meals and general nursing services.
- Semi-private room or ward. If the hospital has private room facilities only, the health plan administrator will determine the average semi-private room rate for the area and benefits will be paid based on that rate.
- Private rooms only when the confinement is required for patients with certain communicable diseases as determined by the health plan. (Private room coverage for reverse isolation is not considered eligible.) Also, if you voluntarily choose a private room, or your physician moves you to a private room from a semi-private, reimbursement will be limited to and based on the most common semi-private room rate of the facility and the specific private room rate charged. The IBM EPO Plan copayment is for a semi-private room. If the hospital bills the higher private room rate, the patient is responsible for paying the difference between the semi-private room rate and private room rate in addition to the IBM EPO copayment. If the hospital does not bill the higher private room rate, the IBM EPO copayment is all the member is responsible for.

Christian Science Sanatoriums

Benefits are based on the prevailing semi-private room rate of general-purpose hospitals in the same geographic area in which the Christian Science Sanatorium is located. *Personal items – guest meals, radio, television, telephone, etc. – are not covered. Private and special duty nurses are not covered.*

Medical Services and Supplies in Connection with Hospital Services

The following inpatient services and supplies are eligible regardless of the type of accommodation occupied, when the services and supplies are ordered by a physician and approved by the hospital in the normal course of diagnosis or treatment of an illness or injury:

- Anesthetic supplies and equipment
- Chemotherapy
- Dressings, plaster casts, splints, trusses, braces and crutches

- Drugs and medication for use in the hospital including radium and radioactive substances
- Electrocardiograph and electroencephalograph equipment
- Intensive care units or coronary care facilities
- Laboratory examinations
- Nursery and premature nursery service, including infant identification bracelet, for eligible family members
- Operating, cystoscopic, delivery and recovery rooms and equipment
- Oxygen
- Physiotherapeutic equipment; physiotherapy
- Prosthetic, orthopedic or other devices such as bone plates and screws, tantalum mesh, nails, pins, bone replacement prostheses, pacemakers, heart valves, vascular tubes and laryngectomy tubes requiring internal fixation by a physician, not removable by the patient at will, for which hospitalization would be required for removal, replacement or repair
- Radiation therapy
- Sera, biologicals, vaccines, intravenous preparations and visualizing dyes, including human blood or blood plasma or other human blood derivatives (this benefit includes the processing, storage and administration)
- Special equipment, including but not limited to special beds and custom-made appliances for use in the hospital X-ray/Imaging diagnosis, supplies and equipment.

Pre-Admission Testing
Standard hospital pre-admission tests billed by the hospital.

Inpatient Professional Fees
If eligible professional services are rendered by a salaried staff employee of the hospital and are billed by the hospital, charges will be reimbursed under hospital services.

Other professional services billed by independent physicians or other providers who are not salaried staff employees of the hospital, for the administration, interpretation or operation of eligible medical supplies and treatments may be eligible for coverage under medical services and reimbursed by the Plan at the applicable primary care physician or physician specialist rate.

In Vitro Fertilization/Artificial Insemination

- Up to two attempts per lifetime of In Vitro Fertilization (GIFT, ZIFT), per health plan administrator, whether or not successful, are eligible. An attempt is defined as the actual procedures for retrieval, fertilization and transfer, and each of the two attempts is eligible for coverage.
- Eligible charges billed by an approved facility will be covered (if the facility is not an approved facility, the charges are not eligible).
- Eligible pre-IVF treatment (i.e., administration of fertility drugs, ultrasounds, lab tests) is also covered.
- Fertility drugs require prior authorization through CVS Caremark (see "Prior Authorization Program" in the IBM Managed Pharmacy Program section). To determine eligibility of fertility drugs, you should contact CVS Caremark, the administrator for the IBM Managed Pharmacy Program.
- Artificial insemination is also covered. There is no limit to the number of attempts.

- Surrogate Parenting is not covered.

Note: You are strongly urged to obtain a predetermination of benefits from the health plan administrator before incurring charges for In Vitro Fertilization to ensure the facility is approved and you have a clear prior understanding of reimbursements. Call the health plan administrator for eligibility of donors for egg/sperm, as well as circumstances where freezing/banking/storage of sperm/embryo and guidelines where ICSI and assisted hatching may be covered. Surrogate parenting is not covered.

Medical Equipment

Basic medical equipment or devices are considered eligible if they are prescribed by a physician and are medically necessary for proper care and treatment of a condition. Examples of items that may be eligible include shoe orthotics, artificial limbs, various aids to impaired organs (such as wheelchairs, heart pacemakers, oxygen equipment and, in some cases, hospital beds) and certain types of monitoring devices. Coverage is provided for standard equipment and only when it is medically necessary. "Take-home" items from a hospital, resulting from an inpatient stay or outpatient treatment, may be eligible under the IBM Plan.

Rental of durable items should be the general practice. However, if there is evidence that the equipment will be required long enough to justify purchase, reimbursement will be limited to the purchase price.

Certain items not necessarily therapeutic in nature, but that allow for increased safety and help prevent injury in "activities of daily living" for individuals who are physically challenged as a result of serious injury or illness, may be considered eligible if prescribed for such an individual by a physician.

These items include:

- Bath/bed/chair lifts which enable a bedridden or wheelchair-bound patient to more readily move to and from the bed or bath
- Bath/shower/tub rails or grab bars which promote safer use of bathing facilities by bedridden or wheelchair-bound patients
- Bedside safety rails as an attachment to prevent falling by a bedridden individual

Multiple Simultaneous Surgical Procedures

If more than one eligible surgical procedure is performed at the same time, reimbursement for the most extensive procedure is based on the full negotiated rate or provider's actual charge, whichever is less, and reimbursement for the additional procedures is based on half of the negotiated rate or the provider's actual charge, whichever is less.

Surgical procedures considered "incidental" to the principal surgery are not eligible for benefit reimbursement. (An "incidental" surgical procedure is one that is performed at the same time as a more complex primary procedure and requires little additional physician resources, or is identified in the primary procedure code.)

Surgical procedures that are mutually exclusive are not eligible ("mutually exclusive" procedures are procedures that, according to medical practice standards, should not be performed on the same patient on the same date of service). You are urged to contact the health plan administrator regarding questions on multiple, simultaneous surgical procedures before the surgery or to obtain a predetermination of benefits.

Nursing Care

Nursing care services must be skilled, provided through a licensed nursing agency, medically necessary and ordered by a physician. Non-agency nurses are not eligible for coverage. Skilled home health nursing care services consist of those services that must be performed by a registered nurse or licensed practical nurse and meet all of the following criteria for skilled nursing services:

- The service(s) must be ordered by a physician.
- The complexity of the service(s) requires a licensed, professional nurse in order to be safely and effectively performed and to achieve the desired medical result.
- The skilled nursing service(s) must be reasonable and necessary for the treatment of the illness or injury, and accepted standards of medical and nursing practice.
- The skilled nursing service(s) is not custodial in nature.

Only services that cannot be performed by a layperson are eligible, such as administration of medications and monitoring of medical support systems or intravenous systems. Services considered primarily custodial in nature by the health plan are not eligible. Custodial care includes:

- Care that provides a level of routine maintenance for the purpose of meeting personal needs and which can be provided by a layperson who does not have licensed or professional qualifications, skill or training.
- Homemaking services, such as meal preparation and housecleaning.
- Custodial care, such as but is not limited to, activities of daily living, help in walking, dressing, eating and routine care of a patient.
- Care of colostomy and ileostomy bags and indwelling catheters, gastrostomy tubes and routine tracheotomies.
- Routine dressing changes, cast care and routine care in connection with braces and similar devices.
- Respiratory therapy — gases (oxygen), routine administration of medical gases after a regimen of therapy has been established.

Note: Private duty nursing services rendered in a hospital setting are not covered.

For the IBM PPO, PPO Plus, IBM Exclusive Provider Organization and IBM PPO with HSA, IBM Enhanced PPO with HSA, nursing services rendered in the home are not covered unless approved by the health plan administrator. Claims received for home health care services that have not been authorized will be denied. A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the home health services are subsequently determined not to be eligible under the terms of the IBM Medical Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed not medically necessary. Only skilled home health care services that are approved by the health plan are medically necessary and meet criteria are eligible for benefits consideration. See "Precertification" earlier in this section for more details.

Nutritional Counseling

Nutritional Counseling rendered by a licensed provider is covered for two visits for patients without a chronic condition and is covered for four visits for patients with a chronic condition such as Crohn's, PKU, cancer, End Stage Renal Disease, Liver Disease, Diabetes, CHF, CAD, COPD, Asthma, Obesity, eating disorders, metabolism disorders, hypertension, hyperlipidemia, anemia, Celiac disease, ALS, MS, Lupus, metabolic syndrome, AIDS or Hepatitis or post bariatric surgery. No further visits will be covered.

Obstetrics
Obstetrics is eligible when performed by a physician in a hospital (inpatient or outpatient), clinic, ambulatory surgical facility, birthing center or at home. Surgical procedures performed as part of an office visit will be subject to the surgical charge and not considered separately. Services provided by a physician acting as an assistant surgeon in complex procedures may also be eligible if determined to be medically necessary by the health plan.

Medical benefits for maternity charges billed by the attending physician/obstetrician for prenatal visits as well as the delivery fee are not reimbursable until after the termination of pregnancy.

Occupational Therapy
Occupational therapy provided by a certified occupational therapist is covered up to a maximum of 40 visits per calendar year when it is prescribed by a physician and necessary for the restoration of an individual's ability to satisfactorily perform daily tasks when this ability was lost due to injury, illness or surgery. Visits beyond 40 are subject to medical necessity review and must be pre-approved by the health plan administrator. You should contact your health plan administrator before your 40th visit so that medical necessity can be determined for future visits.

Claims received for more than 40 visits that have not been authorized will be denied. A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the services are subsequently determined not to be eligible under the terms of the Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed ineligible, including those services which are deemed not medically necessary.

Occupational therapy is not covered when it cannot reasonably be expected to be significantly restorative when a maintenance level has been achieved, or for developmental delays. See the "IBM Special Care for Children Assistance Plan" section.

Outpatient Hospital Services
Coverage is provided for eligible outpatient services performed in a hospital or approved ambulatory surgical facilities. In some cases, laboratories and surgical or diagnostic suites within a hospital building/complex may be privately owned and operated. Facility fees incurred at these privately-owned and operated suites are not eligible for coverage. You are urged to verify eligibility by contacting the health plan administrator before obtaining services.

When you receive services from a hospital, but are not admitted as a registered bed patient, the services listed below are generally eligible:

- Surgical procedures performed on an outpatient basis in the operating room or other surgical facility such as the emergency room of a hospital or an eligible ambulatory surgical center
- Emergency room visits for medical emergencies as the result of a sudden and serious illness (cardiac arrest, convulsions, stomach pains, etc.) or accidental injury
- Diagnostic testing
- Physical therapy
- Observation room stays
- Chemotherapy/radiation
- Home dialysis for kidney failure will be eligible for consideration under hospital services subject to the same guidelines listed in "Medical Services and Supplies in Connection with Hospital Services" if the service is billed by an approved hospital and

- Fees incurred by the actual donor for bone marrow transplants (after coordination with other plans) if the transplant procedure is not considered experimental or investigational. *Note: Registry fees for bone marrow transplants and testing for suitable bone marrow transplant candidates are not covered.* Precertification, evaluation (to determine procedure is not considered experimental or investigational) and approvals are required before transplant. After approval, coverage begins and donor search/fees would be covered. If the person does not get prior approval from the health plan administrator for the transplant, and the claims are submitted to the health plan administrator, the claims will be denied.

Pathology and Radiology (Lab and X-rays)
Eligible pathology and radiology services are covered when necessary for the diagnosis and treatment of an illness or injury and rendered by an eligible provider.

Physical Therapy
Physical therapy rendered by a certified physiotherapist is covered up to a maximum of 40 visits per calendar year when the treatment is prescribed by a physician and necessary for the restoration of function that was lost due to injury, illness or surgery. Therapeutic massage is eligible when rendered as a component of physical therapy in the treatment of a medical condition and when performed by a licensed provider. Visits beyond 40 are subject to medical necessity review and must be pre-approved by the health plan administrator. You should contact your health plan administrator before your 40th visit so that medical necessity can be determined for future visits. Claims received for more than 40 visits that have not been authorized will be denied.

A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the services are subsequently determined not to be eligible under the terms of the IBM Medical Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed ineligible, including those services which are deemed not medically necessary to determine continued eligibility for benefits.

Physical therapy is not covered when it is being rendered to treat a chronic condition where rehabilitation is not the goal, when the therapy has reached the maintenance stage or for developmental delays. See the "IBM Special Care for Children Assistance Plan" section for details.

Pre-Admission Testing
Pre-admission tests required by hospitals before an inpatient confinement (e.g., chest x-ray, urinalysis, CBC) as well as tests related to outpatient surgery are eligible if they are performed and billed by an eligible provider.

Preventive Care Services
Preventive Care Services that fall under the six categories shown below will be reimbursed at 100% and are not subject to the deductible if the service is billed as an eligible Preventive Care Service (and not as a diagnosis for a condition) and is received from an in-network provider.

Services that are not Preventive Care Services and that are not eligible for 100% benefit coverage and/or waiver of deductible may be eligible for coverage under normal Plan provisions. *Note: An office visit before a preventive service may not be eligible for 100% benefit coverage.*

Terms and Conditions:

1. *Any subsequent or follow-up diagnostic testing performed as a result of findings indicated by the Preventive Care Services will not be eligible for 100% reimbursement or waiver of the deductible.*
2. *Services or items described in this section will not be covered or reimbursed under the Plan as Preventive Care Services if they are received by participants who have current symptoms or have been diagnosed with a medical condition associated with those services or items; instead, coverage for the services or items under the Plan will be considered under normal Plan provisions. This determination is made by the health plan Administrator based on the information submitted in the claim for the item or service.*
3. *Routine eye examinations, including preventive tests for visual acuity (refraction), color vision, glaucoma, cataracts and field of vision by an eligible provider (ophthalmologist, optometrist or optician) and expenses for devices (for example, prescription eyeglasses, contact lenses) associated with correction of deficiencies, are not covered under the Plan, but may be covered under the IBM Vision Plan.*
4. *The health plan Administrator may impose limitations on the frequency, method, treatment, or setting for Preventive Care Services provided under the Plan or described in any of the categories below using reasonable medical management techniques.*

The IBM Plan covers services that are graded "A" or "B" by the United States Preventive Services Task Force (USPSTF) as routine preventive care under the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA, and IBM Enhanced PPO with HSA plan options. This list is updated on an ongoing basis by the USPSTF. Please refer to https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations for the most recent list and contact your medical plan administrator with any questions you have. If you are enrolled in an HMO, you must contact the HMO directly to determine whether any of these benefits are covered by the HMO.

Topic	Description
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
Blood pressure screening: adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer screening	Every 1 to 2 years, as determined by the patient's physician.
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding. Costs for renting breastfeeding equipment or for purchasing an electric nonhospital grade breast pump or manual pump will be covered as a Preventive Care Service.
Cervical cancer screening	Women who have been sexually active and have a cervix. Note: The Plan also covers cervical testing for women who are not sexually active as part of the Well Adolescent (Female) Exam and Well Woman Exam described in the 6th category of Preventive Care Services.
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Colorectal cancer screening	Adults, as determined by the patient's physician.

Topic	Description
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	Screening for Type 2 Diabetes Mellitus in Adults. Asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Falls prevention: older adults	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
Screening for Human Immunodeficiency Virus (HIV)	Adolescents and adults at increased risk for HIV infection as determined by the patient's physician. For all sexually active women, counseling and screening for HIV on an annual basis (Effective January 1, 2013). Pregnant women.
Hypothyroidism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Intimate partner violence screening: women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services.
Screening for Iron Deficiency Anemia	For asymptomatic pregnant women, once during pregnancy.
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and counseling: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.

Topic	Description
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
Osteoporosis screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.
Preeclampsia: screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
Skin cancer behavioral counseling	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
Syphilis screening: nonpregnant persons	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.
Syphilis screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.
Unhealthy alcohol use: adults	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
Vision screening: children	Screening To Detect Amblyopia, Strabismus, And Defects In Visual Acuity (i.e., Screenings For Visual Impairment) for children younger than age 5.

The IBM Plan covers services that are graded "A" or "B" by the United States Preventive Services Task Force (USPSTF) as routine preventive care under the IBM Managed Pharmacy Program. This list is updated on an ongoing basis by the USPSTF. Please refer to https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations for the most recent list and contact your medical plan administrator with any questions you have. *Please note that*

a prescription is required for coverage for each item listed below. If you are enrolled in an HMO, you must contact the HMO directly to determine whether any of these benefits are covered by the HMO.

Topic	Description
Aspirin to prevent cardiovascular disease: men	Men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage
Aspirin to prevent cardio vascular disease: women	Women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
Dental caries prevention: infants and children up to age 5 years	Administration of oral fluoride supplementation to prevent tooth decay At currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Screening for Iron Deficiency Anemia	For asymptomatic pregnant women, once during pregnancy.
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
Supplementation with iron	Asymptomatic children aged 6–12 months who are at increased risk of iron deficiency anemia.
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.

The following immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are available under the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA, IBM Enhanced PPO with HSA. If you are enrolled in an HMO, you must contact the HMO directly to determine whether any of these benefits are covered by the HMO.

- Cholera vaccine
- Diphtheria
- (DTP) Diphtheria, Tetanus, Pertussis Hemophilus influenza B vaccine (HIB)
- Hepatitis A and Hepatitis B (HepA-HepB)
- Hepatitis A vaccine
- Hepatitis B vaccine

- Human papilloma virus (HPV) vaccine (e.g. Gardasil)
- Influenza virus vaccine
- Measles vaccine
- (MMR) Measles, Mumps, Rubella
- Meningococcal polysaccharide vaccine
- Mumps vaccine
- Pertussis
- Pneumococcal vaccine
- Poliovirus vaccine
- Rotavirus vaccine (e.g. Rotateq)
- Rubella vaccine
- Shingles (Zoster) vaccine for age 60 and over
- Tetanus
- Typhoid vaccine
- Varicella vaccine
- Yellow fever vaccine

Preventive care services and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration available at www.hrsa.gov.

Preventive care services and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration.

The following additional Preventive Care Services are available under the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA, and IBM Enhanced PPO with HSA. If you are enrolled in an HMO, you must contact the HMO directly to determine whether any of these benefits are covered by the HMO.

Physical Exams and Tests	Description
Newborn Exam	In addition to the screenings recommended for newborns by the United States Preventive Services Task Force described in Category 1, such as hearing testing, PKU screening, and sickle cell screening, the Newborn Exam includes state required congenital screenings, and testing of hemoglobin and hematocrit, glucose, bilirubin and galactose.
Well Child Exam	Includes screenings for hemoglobin and/or hematocrit, tuberculosis, lead and a urinalysis.
Well Woman Exam	Includes preventive care visit annually for adult women to obtain recommended preventive services that are age and developmentally appropriate, including preconception and pre-natal care*. Includes cervical (PAP) test, regardless of whether the woman is sexually active and includes human papillomavirus ("HPV") testing. Several visits may be included in the exam to the extent necessary to obtain all necessary preventive services, dependent on the woman's health status, health needs and other risk factors. * Pre-natal care includes pre-natal obstetrical visits, any lab services required by law to be covered as a Preventive Care Service, and any immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices and are listed above.

Physical Exams and Tests	Description
General Adult Exam	In addition to the cholesterol, hypertension, and osteoporosis screenings recommended by the United States Preventive Services Task Force described in Category 1, the General Adult Exam includes lipid profile, CBC, routing multichannel blood test, glucose, EKG and hearing screening (not including audiometric testing). The General Adult Exam also includes bone mineral density tests that are performed in connection with any osteoporosis screening exam.
Adult Cancer Screening	Adult Cancer Screening includes: ▪ In addition to colorectal cancer screenings recommended by the United States Preventive Services Task Force (*i.e.*, fecal occult blood testing, colonoscopy, or sigmoidoscopy), screen biopsy, polyp removal, anesthesia and facility charges in connection with a colonoscopy or sigmoidoscopy. ▪ Prostate cancer screening, including digital rectal exam (DRE). ▪ Skin cancer screening. ▪ Mammography (which is also recommended by the United States Preventive Services Task Force).

Questions on specific Preventive Care Services covered and any frequency or other limitations on these services should be directed to your health plan using the Member Services number listed on your ID card.

Reconstructive Surgery after Mastectomy
Coverage applies when the mastectomy itself is covered by the Plan and includes reconstructive surgery of the breast on which the mastectomy is performed, reconstructive surgery of the other breast to produce a symmetrical appearance and prostheses and complications of mastectomies, such as lymphedema.

Self-Donated Blood Donations
Processing, storage and administration charges for up to three pints of the patient's self-donated blood for potential transfusion to the patient are eligible for coverage when the patient is scheduled for surgery.

Series of Surgical Treatments
In some instances, it may be necessary to receive a series of surgical treatments or several stages of treatment in order to accomplish total repair or correction. You are urged to obtain a predetermination of benefits from the health plan administrator in advance of each stage of treatment.

Speech Therapy
Speech therapy rendered by an eligible speech pathologist which is prescribed by a physician and an integral part of a total rehabilitation program necessitated either by traumatic injury to the brain (for example, accidental injury, stroke or brain surgery) or by the loss of or injury to an individual's larynx is covered up to a maximum of 40 visits per calendar year. Visits beyond 40 are subject to medical necessity review and must be pre-approved by the health plan administrator. You should contact your health plan administrator before your 40th visit so that medical necessity can be determined for future visits. Claims received for more than 40 visits that have not been authorized will be denied.

A utilization review to determine if the treatments or services are medically necessary and eligible for reimbursement will be required. If some or all of the services are subsequently determined not to be eligible under the terms of the IBM Plan (for example, if it is not medically necessary), you will be responsible for paying the cost of the services deemed ineligible, including those services which are deemed not medically necessary.

Note: Speech therapy is not covered when rendered to treat a chronic condition where rehabilitation is not the goal, when therapy has reached the maintenance state, to refine an individual's existing speech or to educate an individual

whose speech has not yet developed, nor is myofunctional therapy. (See the "IBM Special Care for Children Assistance Plan" section for details.)

Telemedicine
Telemedicine is a "virtual visit" with a physician or other medical professional through your health plan's telemedicine network via the telephone or through your computer. Contact your health plan administrator to inquire about in-network telemedicine providers.

Temporomandibular Joint Dysfunction (TMJ)
In certain rare circumstances, surgical procedures for temporomandibular joint dysfunction (TMJ) may be required and recommended by your provider. Generally, this will only be the case when conventional dental treatment has already been tried and failed to correct the TMJ dysfunction. In such cases, certain surgical procedures may be eligible for coverage under the medical plan options. To determine if medical benefits would apply for TMJ expenses in your particular circumstance, you should consult the health plan administrator before you incur any expenses. All other TMJ-related services are not eligible for coverage under the IBM Medical Plan.

Vision Therapy
Visual therapy services rendered by an optometrist to correct faulty optical fusion or poor coordination of ocular muscles are eligible for coverage. Eligible charges for optometric services include:

- Therapy directed at restoring eye muscle tone and movement after surgery.
- Therapy for faulty optical fusion to muscular imbalance.
- Therapy for amblyopia.
- Therapy for various forms of eye muscle derangement resulting in the diagnosis of diplopia, heterophoria or esotropia.

Visual training administered to improve perceptive powers, either from the standpoint of concentration or comprehension, without the objective of correcting an organic impairment, are not eligible.

Wigs and Toupees
Coverage for wigs and toupees, up to an annual maximum of $2,000 per individual after the annual deductible has been met, only for covered individuals who:

- Have suffered traumatic injuries, including serious burns.
- Have certain medical conditions, such as alopecia (areata, totalis or universalis) and lupus.
- Have experienced hair loss resulting from medical treatment, such as chemotherapy and radiation treatment.

Exclusions: What the IBM Medical Plan Does Not Cover

While the medical plan options cover many services, there are some that are not covered even if your physician or professional provider approves or recommends them. To ascertain if a service is covered, you should call the health plan administrator to verify benefits. Services that are not covered by the medical plan options include, but are not limited to, the following:

- Services received out-of-network, except in an emergency or as described under "*Out-of-Network Medical Coverage.*"
- Expenses related to the completion of your claim form by a third party, medical testimony or medical records.
- Cosmetic services are not eligible under the Plan, except for certain cosmetic surgeries and reconstructive surgery after mastectomy, as specified in "What's Covered Under the IBM Medical Plan."
- Custodial care services are not covered under the Plan. "Custodial" is defined as care that provides a level of routine maintenance for the purpose of meeting personal needs, and which can be provided by a layperson that does not have professional qualifications, skills or training. Custodial care also includes, but is not limited to:
  - Care that does not require a licensed, skilled professional.
  - Homemaking services such as meal preparation and housecleaning.
  - Activities of daily living, including assistance in bathing, dressing, eating or toileting.
  - Routine care such as help in transferring, walking, dressing or eating.
  - Care of colostomy and ileostomy bags, indwelling catheters, gastrostomy tubes, routine tracheotomies, routine dressing changes, cast care and routine care in connection with braces and similar devices.
  - Respiratory therapy — gases (oxygen), routine administration of medical gases after a regimen of therapy has been established.
- Procedures that are *dental* in nature are not covered under the medical plan options, except in the case of treatment for accidental injury to sound natural teeth if the health plan administrator determines that accidental injury coverage applies. Non-surgical TMJ services are not covered under the medical plan options. A procedure is considered "dental in nature" if it primarily is concerned with the teeth, oral cavity and associated supporting structures of the teeth. It includes the prevention, diagnosis and treatment of diseases and injuries of this area. The service may be covered under your dental option (if any). See the "Dental Coverage" section for more information.
- Therapies to treat a *developmental delay or developmental disability,* including physical therapy, occupational therapy or speech therapy, are not eligible. See the "IBM Special Care for Children Assistance Plan" section if your child is being treated for a developmental delay for consideration of these charges.
- *Educational or training services or supplies.* A charge for a service or supply is not covered to the extent that it is determined by the health plan administrator to be educational or training in nature. Charges in connection with such a service or supply are also not covered. "Educational" includes, but is not limited to

- Services or supplies for which the primary purpose is to provide the person with any of the following:
  - Training in the activities of daily living — does not include training directly related to treatment of a sickness or injury that is expected to result in significant physical improvement in the condition within two months of the start of treatment, or that resulted from a previously demonstrated ability to perform those activities, which may be eligible for coverage
  - Instruction in scholastic skills such as reading and writing
  - Preparation for an occupation and
  - Treatment for learning disabilities;
  - Cognitive therapy;
  - Services or supplies provided to promote development beyond any level of function previously demonstrated; and
  - Services or supplies related to lifestyle or wellness programs.

- Out-of-network mental health and substance use charges in excess of 80% of the U&P rate. Any amount of the charges in excess of the U&P rate as determined by the health plan will not be considered in calculating benefits.
- Any *excluded drug or service* listed under the section "Exclusions Under the IBM Managed Pharmacy Program."
- *Experimental or investigational services or supplies.* A treatment or other service or supply (and any other services, supplies or equipment it requires) will generally not be covered if it is experimental or investigational. "Experimental or investigational" means the medical use of a service or supply is still under study and/or is not yet recognized or accepted throughout the medical profession in the United States as safe and effective for diagnosis or treatment of the diagnosed condition. This includes, but is not limited to:
  - All phases of clinical trials.
  - All treatment protocols based on or similar to those used in clinical trials.
  - Federal Food and Drug Administration (FDA) approved drugs, FDA treatment "investigational new drugs" and National Cancer Institute Group C drugs, when used for treatment indications other than those for which the drug's use is recognized throughout the medical profession in the United States.
- Routine *foot care* for removal of corns and calluses.
- The following are specifically excluded with respect to treatment of *Gender Dysphoria*:
  - Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
  - Sperm preservation in advance of hormone treatment or gender surgery
  - Cryopreservation of fertilized embryos
  - Voice modification surgery and
  - Infertility
- *Hair growth* medications or treatments for the restoring, promotion or discouragement of hair growth (e.g. electrolysis) are not eligible.
- *Homeopathic and naturopathic treatments.*
- Incontinence *supplies* are not eligible (e.g., Depends, diapers, etc.).

- Charges incurred at an *ineligible facility* and special units within facilities, including educational facilities, custodial care facilities, special schools, therapeutic schools, wilderness programs, nursing homes, rest homes and homes for the aged or other similar institutions. Charges for room and board in these facilities are not eligible under the IBM Medical Plan. Consult "What's Covered Under the IBM Medical Plan" to see if any charges incurred for medical services while in the facility are eligible for benefits.

  Other facility fees may not be eligible, including:

  - Facility charges incurred as a result of treatment received from a freestanding pain management clinic or pain management departments affiliated/associated with an acute care hospital are not eligible for coverage. Certain medical components may be eligible under "Medical Services" (e.g., physical therapy, etc.). You should contact your health plan to verify eligibility of such charges before incurring the expense.
  - Facility fees incurred at privately-owned and operated laboratories and surgical or diagnostic suites within a hospital building/complex may not be eligible for coverage. You are urged to verify eligibility by contacting your health plan administrator before obtaining services.
- Charges for services which are *not medically necessary*. A charge for a service or supply is not covered to the extent that it is not medically necessary for the treatment or diagnosis of an injury, illness or pregnancy or within the intent of the Plan provisions. Charges in connection with such a service or supply are also not covered. See "What's Covered Under the IBM Medical Plan" for the definition of medically necessary.
- *Marital therapy* is not eligible except through the Employee Assistance Program. See the IBM Managed Mental Health Care Program section for coverage details.
- *Massage Therapy* is not eligible, unless provided as part of physical therapy or chiropractic care.
- *Medical equipment* not eligible for coverage:
  - Medical equipment that is deluxe rather than standard and features that are not medically necessary. Allowance for standard equipment will not be applied towards the cost of deluxe equipment or features.
  - Items that are of general use for non-therapeutic purposes (such as air conditioners, air or water purifiers, mattress/pillow covers, and so on), even if, in your case, it is prescribed for a medical condition.
  - Items that are of general use for physical fitness (such as rowing machines, exercise bicycles, barbells, treadmills and so on), even if, in your case, it is prescribed for a medical condition.
  - Homes, vehicles (other than wheelchairs) or improvements or modifications to a home or vehicle.
  - Common household first-aid items (such as gauze, adhesive tape, heating pads, hot water bottles and so on).
  - Cosmetic items. *Wigs and other hair pieces may be covered under certain circumstances as specified in "What's Covered Under* the IBM Medical Plan."
  - Equipment and supplies the health plan administrator determines are not within the intended scope of coverage or are otherwise ineligible.
  - Back-up equipment is not eligible.
- *Occupational injuries or illnesses* that are covered under Workers' Compensation.

- *Pain Management Clinics.* Facility charges incurred as a result of treatment received from a freestanding pain management clinic or pain management departments affiliated/associated with an acute care hospital are *not* eligible for coverage. Certain medical components may be eligible under medical services (e.g., physical therapy, etc.). You should contact the health plan administrator to verify eligibility of such charges before incurring the expense.
- *Private duty nursing services rendered in a hospital setting* are not covered, since the hospital is expected to provide 24-hour medically necessary nursing care as a part of the services covered by the hospital's room charges.
- *Rest cures, or illness or injury arising from an act of war* if such act occurs while the patient is covered under the Plan. This provision does not apply to eligible care and services furnished in a Veterans Administration hospital in connection with a non-service-related disability.
- *Surrogate Parenting* is not covered.
- *Technology-enabled psychotherapy sessions conducted via telephone, video conference, Skype or other mobile technology* are not a covered benefit under the IBM Managed Mental Health Care Program without the prior approval of the mental health plan administrator.
- Vision exams, services and procedures for changes to *visual refraction,* including LASIK surgery or other eye surgeries, when the primary purpose is to correct myopia, hyperopia or astigmatism. (See the "Vision Coverage" section for information about the IBM Vision Plan.)

IBM Mental Health Care Program

IBM Mental Health Care Program

ABOUT YOUR MENTAL HEALTH CARE COVERAGE

The IBM Mental Health Care Program is designed to help eligible employees and their covered family members to resolve personal problems and concerns through confidential evaluation and assessment services, access to online information and inpatient/outpatient treatment.

OUT-OF-NETWORK SERVICES

Mental health services will generally continue to be covered out-of-network. However, the Plan will not cover out-of-network, non-urgent residential and day rehabilitation services received outside the covered IBMer's state of residence, or immediate bordering state. (This will not apply to urgent care, students attending out-of-state schools or those with dual addresses.)

Contact Optum directly to learn more.

The Mental Health Care Program has three components:

- The Clinical Referral Line (CRL) is a 24-hour toll-free number that's answered by mental health clinicians who will assist you in accessing the mental health services provided by the IBM Mental Health Care Program including the Employee Assistance Program, the Managed Mental Health Care Program. The Clinical Referral Line is available to all employees, regardless of their medical plan option.
- The Employee Assistance Program (EAP) provides up to eight counseling sessions with an EAP clinician at no cost to you. The EAP is available to all employees regardless of their medical plan option.
- The Managed Mental Health Care (MMHC) Program provides more intensive outpatient and inpatient treatment to participants in the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA options through a qualified network of treatment providers and/or facilities. In addition to face-to-face EAP and MMHC outpatient sessions, eligible members can also access care through Mind Virtual Health, which uses secure, web-based videoconferencing with an Optum provider of your choosing.

MENTAL HEALTH PLAN ADMINISTRATOR

For the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA, the administrator for the Managed Mental Health Care Program is Optum by United Behavioral Health, a managed behavioral health care organization.

Clinical Referral Line

The Clinical Referral Line is available for precertification 24 hours a day, 365 days a year.

Customer Service Availability

Customer Services Representatives are available for claims and non-clinical inquiries Monday through Friday, 8 a.m. to 7 p.m. Eastern time, excluding holidays.

You can reach Optum at 800-445-9720
(TTY: Dial 711 and enter 800-445-9720

WHO IS ELIGIBLE

The Clinical Referral Line and Employee Assistance Program are available to all eligible employees and their eligible family members, including HMO enrollees and employees, retiree supplementals and long-term supplementals who have waived IBM medical coverage. The Managed Mental Health Care Program is available only to participants enrolled in the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO

with HSA and IBM Enhanced PPO with HSA. Note that other IBM-sponsored medical plans provide mental health/substance use benefits under the terms of their plans.

Employees enrolled in the IBM Global Assignee Medical Plan are not eligible for benefits through the Employee Assistance Program or the IBM Managed Mental Health Care Program. Coverage for these services is received through the IBM Global Assignee Medical Plan administered by Cigna Global Health Benefits.

Managed Mental Health Plan Administrator

The administrator for the Managed Mental Health Care Program is Optum by United Behavioral Health, a managed behavioral health care organization. For the HMOs, the individual health plan is the administrator for mental health/substance use benefits.

CLINICAL REFERRAL LINE

The Clinical Referral Line (CRL) is staffed by mental health professionals with clinical experience in the areas of mental health care and substance use treatment. These clinicians are employed by Optum, and it is their responsibility to ask you several questions regarding the clinical nature of your situation to determine what options are available to you based on the Plan provisions.

To access clinical services, precertify EAP and Mental Health Care Program care and/or identify network providers in your area, call the IBM-dedicated Clinical Referral Line 24 hours a day, 7 days a week at 800-445-9720. If care is medically necessary at the time of your call to the Clinical Referral Line, your care will be precertified during your call. (See "MMHC Precertification" later in this section for more information.)

Call the Clinical Referral Line To...

- Review your clinical needs and discuss treatment options.
- Determine whether a provider is in the network at the time of the inquiry.
- Receive a referral to a local EAP clinician for a comprehensive assessment and, when appropriate, counseling.
- Identify a local EAP clinician, make an appointment with a local EAP clinician if requested or get information for the nearest psychiatric facility, emergency room or treatment provider if necessary. (See "MMHC Emergency Care Coverage" for more information.)
- Precertify your care before obtaining EAP treatment.
- Receive a referral to your local MMHC network provider, or HMO or other non-IBM health plan, when EAP counseling is not appropriate or has been exhausted.
- Precertify your care before obtaining treatment. Any time you go to a new provider, facility or program, even if your EAP clinician or your current MMHC provider recommended the new provider, you must call the Clinical Referral Line first to determine if precertification is required for any reimbursement under the IBM EPO option and for the highest level of reimbursement under the IBM PPO, IBM PPO Plus, IBM PPO with HSA and IBM Enhanced PPO with HSA options.
- Identify if a non-network MMHC provider may be eligible for payment under the Plan. (See "MMHC Provider Network.")
- Determine if the proposed treatment is reimbursable under the Plan.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP can help when you need assistance with a personal or work-related problem. In most cases, issues can be resolved effectively within the EAP. Some people will require more specialized or longer-term treatment. In these situations, the EAP clinician will assist you in connecting with an appropriate MMHC provider, if eligible, or with your HMO or other group health coverage.

EAP clinicians are independently licensed mental health/substance use-disorder treatment professionals who are contracted with the Mental Health Care Program administrator.

The services of the EAP, include up to eight face-to-face or mind virtual health counseling sessions per issue with an EAP clinician and a comprehensive evaluation and treatment plan, are provided at no cost to you or your eligible family members. The EAP is not intended for long-term treatment of an ongoing problem. Any sessions beyond the eight EAP sessions will not be covered. If you have completed EAP sessions for one specific issue, you may use the EAP again for the same issue after a minimum wait of 90 days, regardless of the Plan Year as long as you have not been receiving ongoing treatment for this issue through the mental health portion of your benefit.

The EAP can help you with a variety of issues including:

- Parenting concerns
- Marriage and family issues
- Alcohol and drug problems
- Stress related to financial and legal situations
- Emotional stress
- Improving communication at work or home
- Life crises
- Other personal issues

EAP services are entirely voluntary. EAP clinicians are not employees or contractors of IBM, nor are they located on IBM premises. No one will be told of your participation in the EAP without your permission, except as required by law in a situation deemed potentially life threatening by a clinician, or to review an appeal initiated by you. See "Confidentiality" for more information.

If You Need Treatment Beyond the Eight EAP Sessions

If You Are Eligible for the Managed Mental Health Care Program

If you are covered under the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA or IBM Enhanced PPO with HSA and require further assistance beyond the EAP assessment, you may continue with your current EAP provider, or you may be referred to a provider in the MMHC provider network. The EAP clinician is allowed to provide treatment under the MMHC, but care must be precertified once it is determined that the issue would involve support beyond the EAP assessment. If you are referred to a MMHC provider by the EAP counselor, it is your responsibility to call the Clinical Referral Line to precertify your care.

The decision to use a provider to whom you are referred through the EAP is your responsibility. Each EAP clinician and each provider to whom referrals are made is responsible for the care they provide. The EAP is not intended for long-term treatment of an ongoing problem.

If You Are Not Eligible for the Managed Mental Health Care Program
If you are enrolled in an HMO or opt-out of IBM coverage, you will need to contact your administrator for additional treatment assistance beyond the eight EAP maximum visits and/or EAP assessment, whichever occurs first. The EAP clinician can assist you in contacting your HMO or other group health coverage.

The decision to use a provider to whom you are referred through the EAP is your responsibility. Each EAP clinician and each provider to whom referrals are made is responsible for the care they provide. The EAP is not intended for long-term treatment of an ongoing problem.

IBM MANAGED MENTAL HEALTH CARE PROGRAM

Managed Mental Health Care Program At-A-Glance

The chart below provides an overview of what the Plan covers for covered mental health and substance use services, depending on the medical plan option in which you enroll.

	IBM PPO and IBM PPO Plus (In-Network)	IBM PPO and IBM PPO Plus (Out-of-Network)	IBM EPO (In-Network Only)
Mental Health Care Program At-A-Glance			
Administrator	Optum by United Behavioral Health (under the IBM Managed Mental Health Care Program)	Optum by United Behavioral Health (under the IBM Managed Mental Health Care Program)	Optum by United Behavioral Health (under the IBM Managed Mental Health Care Program)
Annual Deductible	Shared with Medical[1]	$2,800/$8,400	Shared with Medical[1]
Precertification for mental health/substance use benefits	Precertification is required for inpatient services received in network; and you will be responsible for all costs of care not deemed medically necessary.	Precertification is required for inpatient services received out of network; otherwise, a $150 penalty will apply, and you will be responsible for all costs of care not deemed medically necessary.	Precertification is required for inpatient services received in network; and you will be responsible for all costs of care not deemed medically necessary.
Annual Out-of-Pocket Maximum	Shared with Medical[1, 2]	$17,550/$31,600	Shared with Medical[1, 2]
Lifetime Benefit Maximum (per person/combined with medical)	Unlimited	Unlimited	Unlimited
MMHC MENTAL HEALTH AND SUBSTANCE USE BENEFITS			
Inpatient Care	20% after medical deductible Precertification required	45% after medical deductible Precertification required [3, 4, 5]	$1,200 copay per admission Precertification required
Outpatient Care	20% Precertification required for non-routine services	45% after medical deductible Precertification required for non-routine services[4]	25% Precertification required for non-routine services

[1] See annual deductibles and out-of-pocket maximums listed on the Medical Plan Options at a Glance page. Under the IBM PPO, IBM PPO Plus and IBM EPO options, medical and mental health/substance use services are subject to the deductible. Under the IBM PPO with HSA and IBM Enhanced PPO with HSA, medical, mental health/substance use services and non-preventive prescription drugs are subject to the deductible. For all plan options, eligible medical, mental health/substance use and prescription drug expenses accumulate to the out-of-pocket maximum.

[2] Mental health/substance use services will be covered at 100% once an individual's eligible out-of-pocket expenses (medical, mental health/substance use, prescription drugs or a combination of these) reaches the out-of-pocket maximum or once the family out-of-pocket maximum is reached.

[3] Precertification is required for inpatient services received out of network; otherwise, a $150 penalty will apply, and you will be responsible for all costs of care not deemed medically necessary.

	IBM PPO and IBM PPO Plus (In-Network)	IBM PPO and IBM PPO Plus (Out-of-Network)	IBM EPO (In-Network Only)

[4] Outpatient treatment from an eligible out-of-network provider will be covered at 55% of the usual and prevailing rate, after the deductible.

[5] There is no coverage for out-of-network, non-urgent residential and day rehabilitation services received outside the IBMer's state of residence or immediate neighboring state. Exclusion does not apply to urgent care, students attending school out of state or those with dual addresses.

	IBM PPO and IBM Enhanced PPO with HSA (In-Network)	IBM PPO and IBM Enhanced PPO with HSA (Out-of-Network)
Mental Health Care Program At-A-Glance		
Administrator	Optum by United Behavioral Health (under the IBM Managed Mental Health Care Program)	Optum by United Behavioral Health (under the IBM Managed Mental Health Care Program)
Annual Deductible	Shared with Medical[1]	Shared with Medical[1]
Precertification for mental health/substance use benefits	Precertification is required for inpatient services received in network; and you will be responsible for all costs of care not deemed medically necessary.	Precertification is required for inpatient services received out of network; otherwise, a $150 penalty will apply, and you will be responsible for all costs of care not deemed medically necessary.
Annual Out-of-Pocket Maximum	Shared with Medical[1, 2]	$16,550/$29,800
Lifetime Benefit Maximum (per person/combined with medical)	Unlimited	Unlimited
MMHC MENTAL HEALTH AND SUBSTANCE USE BENEFITS		
Inpatient Care	25% after medical deductible Precertification required	45% after medical deductible Precertification required[3, 4, 5]
Outpatient Care	25% for office visits after medical deductible 30% for all other services after medical deductible Precertification required for non-routine services	45% after medical deductible Precertification required for non-routine services[4]

[1]See annual deductibles and out-of-pocket maximums listed on the Medical Plan Options at a Glance page. Under the IBM PPO, IBM PPO Plus and IBM EPO options, medical and mental health/substance use services are subject to the deductible. Under the IBM PPO with HSA and IBM Enhanced PPO with HSA, medical, mental health/substance use services and non-preventive prescription drugs are subject to the deductible. For all plan options, eligible medical, mental health/substance use and prescription drug expenses accumulate to the out-of-pocket maximum.

[2]Mental health/substance use services will be covered at 100% once an individual's eligible out-of-pocket expenses (medical, mental health/substance use, prescription drugs or a combination of these) reaches the out-of-pocket maximum or once the family out-of-pocket maximum is reached.

[3]Precertification is required for inpatient services received out of network; otherwise, a $150 penalty will apply, and you will be responsible for all costs of care not deemed medically necessary.

[4]Outpatient treatment from an eligible out-of-network provider will be covered at 55% of the usual and prevailing rate, after the deductible.

[5]There is no coverage for out-of-network, non-urgent residential and day rehabilitation services received outside the IBMer's state of residence or immediate neighboring state. Exclusion does not apply to urgent care, students attending school out of state or those with dual addresses.

MMHC In-Network Care

If you are enrolled in the IBM PPO, IBM PPO Plus, IBM PPO w/HSA or IBM Enhanced PPO with HSA option, you have the choice to obtain care from either in-network or out-of-network providers/facilities, but you will receive the highest level of benefits when you obtain care from an in-network

provider/facility. Under the IBM EPO option, mental health/substance use-disorder treatment is available only from in-network providers/facilities. You must precertify non-routine in-network inpatient and outpatient care by calling the Clinical Referral Line.

For reimbursement under the Plan, in-network care must meet medical necessity criteria and is subject to review by the mental health plan administrator. You should verify in advance if the proposed facility and program meet the Plan's criteria for coverage — unless emergency care is needed. If a network provider, facility, or treatment program fails to obtain precertification from the mental health plan administrator before providing inpatient treatment, no benefits will be paid to the provider. Network providers may not bill you or the Plan for care that has not been precertified. If this occurs, you are still responsible for paying your deductible, coinsurance or copayment, whichever is applicable.

Covered Services

Covered mental health care and substance use services include those received on an inpatient or outpatient basis in a hospital, an alternative facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits are payable for:

- Inpatient treatment.
- Residential treatment.
- Partial hospitalization/day treatment.
- Intensive outpatient treatment.
- Outpatient treatment.

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds).

Covered services include:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

MMHC In-Network — Outpatient Care

- *IBM PPO, IBM PPO Plus Options:* If you call the Clinical Referral Line and precertify non-routine care before receiving outpatient treatment from an in-network provider, your care will be covered at 80%. Routine outpatient care from an in-network provider will be covered at 80% without precertification. There is no limit on medically necessary, in-network outpatient care. Your provider must continue to certify ongoing non-routine care in order to continue to be reimbursed at the in-network level. If you fail to precertify in-network non-routine outpatient care by calling the Clinical Referral Line, you will receive no benefits. To determine if care is routine or non-routine, call the Clinical Referral Line. See "MMHC Precertification" for details.

- *IBM PPO with HSA and IBM Enhanced PPO with HSA options:* If you call the Clinical Referral Line and precertify non-routine care before receiving outpatient treatment, your care will be covered at 75% for office visits after the deductible is met and 70% for all other services after the deductible is met. Routine outpatient care from an in-network provider will be covered at 75% after the deductible without precertification. There is no limit on medically necessary, in-network outpatient care. Your provider must continue to certify ongoing non-routine care in order to continue to be reimbursed at the in-network level. If you fail to precertify in-network non-routine outpatient care by calling the Clinical Referral Line, you will receive no benefits. To determine if care is routine or non-routine, call the Clinical Referral Line. See "MMHC Precertification" for details.
- *IBM EPO Option:* If you call the Clinical Referral Line and precertify non-routine care before receiving outpatient treatment from an in-network provider, your care will be covered at 75%. Routine outpatient care from an in-network provider will be covered at 75% without precertification. Your provider must continue to certify ongoing non-routine care in order to continue to be reimbursed at the in-network level. Care received outside of the provider network will not be covered. If you fail to precertify outpatient care, you will receive no benefits. To determine if care is routine or non-routine, call the Clinical Referral Line. See "MMHC Precertification" for details.

MMHC In-Network — Inpatient Care

If you require inpatient care, your network provider/facility will seek precertification of an inpatient or alternative level of care admission on your behalf. The network provider/facility must also precertify ongoing care on your behalf. It is your responsibility to tell the network program/facility that you are covered under the IBM Managed Mental Health Care Plan administered by Optum. The administrator will review the precertification request to determine if the treatment meets medical necessity criteria and is the appropriate level of care. The administrator will then precertify your care for a certain number of treatment days with no predetermined limit

- *IBM PPO and PPO Plus Options:* Once you satisfy the annual deductible, you are eligible for medically necessary unlimited inpatient treatment days for mental health and substance use care, covered at 80%.
- *IBM PPO with HSA and IBM Enhanced PPO with HSA Options:* Once you satisfy the annual deductible, you are eligible for unlimited medically necessary inpatient treatment days for mental health and substance use care, covered at 75%.
- *IBM EPO Option:* After a $1000 copayment per admission, inpatient care is covered at 100% for unlimited medically necessary inpatient treatment days for mental health and substance use care.

If a network facility or treatment program fails to obtain precertification from the mental health Plan Administrator before providing inpatient treatment, no benefits will be paid to the provider. Network providers may not bill you or the Plan for care that has not been precertified. If this occurs, you are still responsible for paying your deductible, coinsurance or copayment, whichever is applicable.

Important Terms

- *Applied Behavior Analysis* - the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.
- *Autism Spectrum Disorder* - any pervasive developmental disorders set forth in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*, including but not limited to Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified

- *Behavioral Therapy (IBT)* - outpatient mental health care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.
- *Intensive outpatient treatment* - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or hospital-based and provides services for at least three hours per day, two or more days per week
- *Mental health care services* - covered health care services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. The fact that a condition is listed in this publication does not mean that treatment for the condition is a covered health care service.
- *Mental illness* - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. The fact that a condition is listed in this publication does not mean that treatment for the condition is a covered health care service.
- *Partial hospitalization/day treatment* - a structured ambulatory program. The program may be freestanding or hospital-based and provides services for at least 20 hours per week.
- *Residential treatment* - treatment in a facility established and operated as required by law, which provides mental health care services or substance-related and addictive disorders services. It must:
  - Provide a program of treatment, approved by the mental health/substance-related and addictive disorders designee, under the active participation and direction of a physician and, approved by the mental health/substance-related and addictive disorder designee;
  - Have or maintain a written, specific and detailed treatment program requiring your full-time residence and participation; *and*
  - Provide at least the following basic services in a 24-hour per day, structured setting:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

  A residential treatment facility that qualifies as a hospital is considered a hospital.
- *Substance use services* - covered health care services to diagnose and treat of alcoholism and substance-related and addictive disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. The fact that a disorder is listed in this publication does not mean that treatment of the disorder is a covered health care service.
- *Transitional living* - mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:
  - Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

- *Usual and Prevailing (U&P) Rate:* This is the reimbursement rate used by the administrator of your plan option to determine the maximum amount that is eligible for reimbursement of a treatment, service or supply. The method that the administrator of your plan option uses to determine the reimbursement rate may be based on a percentage of the current Medicare rates, FAIR health table, or other nationally recognized database. Amounts above 80% of the U&P rate are considered ineligible expenses and will not count toward either the annual deductible or annual out-of-pocket maximum.

MMHC Out-of-Network Care

If you are enrolled in the IBM PPO, IBM PPO Plus, IBM PPO with HSA, or IBM Enhanced PPO with HSA option, you may generally continue to receive care from out-of-network providers. Keep in mind that out-of-network care is reimbursed at a lower benefit than in-network care. You must precertify non-routine out-of-network outpatient care and out-of-network inpatient care by calling the Clinical Referral Line.

Remember that there is no coverage for out-of-network, non-urgent residential and day rehabilitation care received outside of your state of residence (or the immediate bordering state). This does not apply to urgent care, students attending out-of-state schools or those with dual addresses. For those who need to change facilities due to this coverage change, contact Optum directly to learn more.

For reimbursement under the Plan, out-of-network care must meet medical necessity criteria and is subject to review by the mental health Plan Administrator. You should verify in advance if the proposed facility and program meet the Plan's criteria for coverage — unless emergency care is needed. You will be responsible for paying 100% of charges with an out-of-network provider/facility if the care is determined not to be medically necessary or if the charges, provider or facility is not eligible for benefits under the Plan. See "MMHC Provider Network" and the definition of "Medical Necessity" later in this section for more information.

There is no out-of-network coverage for the IBM EPO option.

MMHC Out-of-Network — Outpatient Care

Under the IBM PPO, IBM PPO Plus, IBM PPO with HSA or IBM Enhanced PPO with HSA options. If you call the Clinical Referral Line and precertify non-routine care before receiving outpatient treatment from an eligible out-of-network provider, your care will be covered at 55% of the U&P rate after deductible. Routine outpatient care from an eligible out-of-network provider will be covered at 55% of the U&P rate after deductible without pre-certification. There is no limit on medically necessary, out-of-network outpatient care. Your provider must continue to certify ongoing non-routine care in order to continue to be reimbursed at the out-of-network level. If you fail to precertify out-of-network non-routine outpatient care by calling the Clinical Referral Line, you will receive no benefits. To determine if care is routine or non-routine, call the Clinical Referral Line. See "MMHC Precertification" for details.

ELIGIBLE PROVIDERS

Eligible Providers under the MMHC include:

- Licensed psychiatrists (MD-Board-Certified preferred)
- Doctoral-level licensed psychologists (PhD, PsyD, EdD)
- Licensed professional counselors (LPC)
- Licensed masters-level social workers (LCSW/LICSW)
- Licensed mental health counselors (LMHC)
- Licensed marriage and family therapists (LMFT and
- Licensed masters-level psychiatric nurses (APRN/RNCS).

Due to the varying nature of provider credentials, you should call the Clinical Referral Line to verify that an out-of-network provider is eligible for reimbursement under the Plan. Claims are processed based on the actual provider of services, not on any supervision arrangement with another mental health care provider.

Note: Pastoral counselors are not eligible for reimbursement under the Plan.

MMHC Out-of-Network — Inpatient Care

Under the IBM PPO, IBM PPO Plus, IBM PPO with HSA or IBM Enhanced PPO with HSA options, you must call the Clinical Referral Line and precertify care before receiving out-of-network inpatient treatment. If your care is deemed medically necessary, once you satisfy the annual deductible, your out-of-network care will be covered at 55% of the U&P rate.

If you fail to precertify out-of-network inpatient care, you will receive no benefits. You will be responsible for an additional $150 penalty if the care is determined to be medically necessary. Federal, state or municipal facilities may be considered out-of-network and must be approved by the mental health plan. See "MMHC Precertification" for details.

MMHC Out-of-Network Provider Review

It is your responsibility to ensure the out-of-network provider/facility and treatment plan are eligible for reimbursement under the Plan. Upon request, out-of-network programs will be reviewed by the mental health Plan Administrator to determine if the program is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as either a hospital or freestanding substance use program or accredited by the appropriate state agency as a substance use program. Programs and facilities not meeting either of these criteria will not be eligible for benefit coverage under the Plan. (See "MMHC Alternative Levels of Care" for criteria.)

MMHC Provider Network

The mental health plan maintains a nationwide network of participating providers. The contracted network includes licensed psychiatrists (Board-Certified preferred), doctoral-level licensed psychologists, licensed masters-level social workers, licensed professional counselors (LPC), marriage and family counselors and licensed masters-level psychiatric nurses for outpatient care, as well as treatment programs and facilities which provide a full continuum of intensive treatment. All clinicians in this network providing outpatient treatment must be licensed at the highest independent practice level, and clinicians, treatment programs and facilities must meet credentialing requirements.

It's your responsibility to choose a provider. Selecting a provider who participates in the network will result in a higher level of benefits. When choosing a provider, you should consider their eligibility and network status because benefit payment will be determined by these factors. To obtain referrals or information about programs that are part of the mental health plan's network or to verify your provider's eligibility, call the Clinical Referral Line.

Keep in mind that provider networks change from time to time. You should call the Clinical Referral Line before obtaining services from the provider you have selected to find out whether that provider is in the administrator's network, even if you have used the same provider in the past. Each provider, whether or not in the mental health plan's network, is solely responsible for the care provided, and neither the mental health plan nor IBM makes any representations regarding such care. Your selection of a provider and verification of network or non-network status is your responsibility.

MMHC Precertification

To receive the maximum level of benefits available, you must precertify certain mental health/substance use care as explained below.

IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA Options

Under the IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA options, you are required to call the Clinical Referral Line before obtaining in-network and out-of-network inpatient and non-routine outpatient mental health/substance use treatment. Routine outpatient care does not require precertification. When you call, the mental health plan will recommend and certify benefits for treatment which is determined to be clinically appropriate and medically necessary. This decision is based on medical necessity guidelines. The Clinical Referral Line can also help you determine if outpatient care is routine or non-routine.

Please note that if you are enrolled in the IBM EPO, the plan only allows in-network care.

When you call, identify yourself as an IBM participant.

If you do not precertify inpatient or non-routine outpatient care, you will receive no benefits. Only care that is medically necessary will be covered. If the care is determined not to be medically necessary, you will not receive benefits under the Plan.

Medical Necessity

The mental health plan certifies treatment for benefit coverage only if it's considered to be medically necessary. To be medically necessary treatment must:

- Be medically required.
- Have a strong likelihood of improving your diagnosed psychiatric or substance use condition.
- Be the least intensive level of appropriate care for your diagnosed condition in accordance with:
  - Generally-accepted psychiatric and mental health practices.
  - *The professional and technical standards adopted by the mental health plan.*
- Not be rendered mainly for the convenience of the member, the member's family or the provider.
- Not be custodial care. (See "What the IBM Medical Plan Does Not Cover" for a definition of custodial care.)

Note: Determination of medical necessity does not guarantee benefit reimbursement. Benefit reimbursement under the MMHC Program is subject to plan provisions, member eligibility at the time services are rendered, annual deductibles, facility/treatment eligibility and lifetime maximums.

Precertifying Additional Sessions/Days
When you, or a treatment provider/facility, call to precertify inpatient in-network or out-of-network care, the mental health plan will certify benefits coverage with a specified start and end date to be paid at the in-network benefit level.

If you require additional treatment at the time that your precertification for non-routine outpatient visits or inpatient days have been exhausted, or the certification end date occurs, your provider must contact the mental health plan to certify the additional treatment. See "Mental Health Plan Administrator's Clinical Staff and Ongoing Reviews" for more information.

The additional treatment will be reviewed by the mental health plan to determine continuing medical necessity. If ongoing care is deemed medically necessary, it will be certified by the mental health plan. Please keep in mind that certification does not guarantee benefits are available; if the member is not eligible at the time of treatment.

When the IBM Medical Plan Is Secondary
If you have medical coverage through another group health plan or other coverage and the IBM Medical Plan is secondary to that other coverage, you do not need to precertify mental health/substance use care. For Medicare-eligible participants, in order to receive the highest level of reimbursement, the facility/provider must accept Medicare *and* be in the Optum network.

If Medicare is your primary coverage you must use providers and facilities that accept Medicare. When you obtain services, such as mental health and/or substance use services from a provider or facility that does not accept Medicare, those services are not eligible for any reimbursement under the IBM Plan.

Note: Refer to "Coordinating IBM Medical Coverage with Medicare" in the Administrative Information section for more information about coordination of benefits with Medicare.

Additional Covered Benefits Under the MMHC Program

Service	Benefits* (amount the Plan pays after your deductible)
Electroconvulsive Therapy (ECT)	Inpatient and outpatient ECT require precertification in-network and out-of-network IBM PPO, IBM PPO Plus (Inpatient and Outpatient) In–network: Facility, Physician, Anesthesia – 80% Out-of-network: Facility, Physician, Anesthesia – 55% PPO with HSA and IBM Enhanced PPO with HSA (Inpatient) In-network: Facility, Physician, Anesthesia – 75% Out-of-network: Facility, Physician, Anesthesia – 55% IBM PPO with HSA and IBM Enhanced PPO with HSA (outpatient) In-network: Facility, Physician, Anesthesia - 70% Out-of-network: Facility, Physician, Anesthesia – 55% IBM EPO (Inpatient) In-network Facility: $1,200 copayment per admission In-network Physician and Anesthesia: 100% IBM EPO (Outpatient) In-network Facility, Physician and Anesthesia: 75%

Service	Benefits* (amount the Plan pays after your deductible)
Marriage and Family Counseling	Marriage counseling is only eligible under the Employee Assistance Program. No reimbursement will be received under the Managed Mental Health Care component of the Plan. Family counseling is eligible under the Employee Assistance Program and eligible for reimbursement under the Managed Mental Health Care component of the Plan.
Medication Management Sessions	Medication management visits with in-network providers are covered at: ▪ 80% IBM PPO and IBM PPO Plus ▪ 75% for IBM EPO, IBM PPO with HSA and IBM Enhanced PPO with HSA Visits with an out-of-network provider are covered at 55% of U&P rate*. Medication management is not covered under the Employee Assistance Program.
Psychological Testing	Precertified outpatient psychological testing is covered at 80% (IBM PPO, IBM PPO Plus) 75% (IBM EPO,IBM PPO with HSA and IBM Enhanced PPO with HSA), when received from an in-network provider. Precertified outpatient psychological testing is covered at 55% of the U&P rate when received from an out-of-network provider. If psychological testing is not precertified, you will receive no benefits. Psychological testing must be rendered by a licensed doctoral-level psychologist (Ph.D.) or with the exception and/or certification of the mental health plan. Psychological testing for developmental, education or learning disabilities is not eligible under the Managed Mental Health Care Program. (Refer to the "Special Care for Children Assistance Program" for possible coverage.)
Psychotherapy	Only one session for psychotherapy per day is eligible for payment under the Plan. When a claim is submitted for psychotherapy provided on an outpatient or an inpatient basis, benefits are payable for up to one session (maximum) for the same service on any given day. A session is defined by the Current Procedural Terminology (CPT) code billed by the provider. Most CPT procedure codes describe the service provided and the amount of time recommended for the session or service. However, benefits are payable for two different services on the same day.

* There is no out-of-network coverage for the IBM EPO option.

Exclusions

The following are exclusions to services provided under the MMCH Program

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).*
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).*
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
- Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Out-of-network, non-urgent residential and day rehabilitation services received outside the IBMer's state of residence or immediate bordering state. This exclusion does not apply to urgent care, students attending school out of state or those with dual addresses.
- Tuition or services that are school based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act

- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*.
- Intensive Behavioral Therapy for Autism Spectrum Disorder, including Intensive Behavioral Therapy such as Applied Behavior Analysis (ABA). See the "IBM Special Care for Children Assistance Plan" section if your child is being treated for a developmental delay for consideration of these charges.

MMHC Emergency Care Coverage

In the event of a mental health emergency, you should call 911 or immediately go to the nearest emergency room. You, or your representative such as a family member or friend, must present your medical plan ID card to identify yourself as a Plan participant. In an emergency, a network hospital must seek certification of the care within 48 hours. If you go to an out-of-network hospital, either you or your attending physician's office, or your representative such as a family member or friend, must call the Clinical Referral Line to seek certification of care within 48 hours.

If you fail to obtain precertification within 48 hours of an out-of-network inpatient admission, you will receive no benefits. You will be responsible for an additional $150 penalty if the care is determined to be medically necessary. In addition, you will be responsible for all charges for care deemed not medically necessary by the Plan.

HOW EMERGENCY IS DEFINED

"Emergencies" are defined as severe psychiatric or substance use conditions which render you incapable of providing accurate benefits information at the time of admission to the hospital or incapable of following the provisions of the Plan. The mental health Plan will authorize benefit coverage for hospital admissions deemed medically necessary by the Plan.

In these severe situations, administering appropriate treatment should occur immediately to ensure safety before determining whether care is eligible under the Plan.

Out-of-Network Emergency Care

Care at an out-of-network hospital will be certified as "in-network" during the stabilization period for an emergency admission *only* following notification and if the patient accepts a transfer to a network facility after the patient has been stabilized. If the patient does not accept the transfer to an in-network facility/treatment program, benefits will be paid at the out-of-network rate if care is precertified.

MMHC Alternative Levels of Care

Alternative levels of care may be approved by the mental health plan in lieu of inpatient treatment as clinically-appropriate and cost effective. Alternative levels of care include residential treatment, group homes, halfway house, partial hospitalization or intensive outpatient treatment.

Note: Wilderness programs, therapeutic schools, and non-medical facilities or their component services are not eligible for reimbursement under the IBM Plan nor are they eligible for alternative level of care.

If an alternative level of treatment care is proposed, the mental health plan will:

- Determine if an alternative level of care is medically necessary.
- Determine if alternative care is a clinically appropriate alternative to hospitalization.
- Approve an appropriate facility that meets the credentialing criteria for in-network reimbursement.

Alternative Levels of Care Under the IBM PPO, IBM PPO Plus, IBM PPO with HSA, IBM Enhanced PPO with HSA, and IBM EPO Options

To be eligible for the highest level of reimbursement under IBM PPO, IBM PPO Plus, IBM PPO with HSA, IBM Enhanced PPO with HSA and IBM EPO options alternative levels of care must be precertified and must receive case management review by the mental health plan. Alternative levels of care are subject to the inpatient in-network and out-of-network benefit. If pre-certification is not obtained, you will receive no benefits. Out-of-network services are subject to a $150.00 penalty if not precertified and deemed to be medically necessary. Alternative levels of care only available in-network for IBM EPO option.

MMHC Benefit Payment

Benefit payment under the Managed Mental Health Care Program is subject to Plan provisions, annual deductibles, coinsurance, copayments and lifetime maximums.

Annual Deductibles for Mental Health/Substance Use Treatment

- *IBM PPO, IBM PPO Plus, IBM PPO with HSA and IBM Enhanced PPO with HSA Options:* Mental health/substance use charges are applied to the IBM PPO, IBM PPO Plus, IBM PPO with HSA and IBM Enhanced PPO with HSA medical deductibles (combined with medical services). See "Managed Mental Health Care Program At-A-Glance" chart for details.
- *IBM EPO Option:* A separate $1200 copayment applies per admission for mental health/substance use in-network inpatient care. Coinsurance is also required for outpatient visits. See the "Non-Medicare-Eligible: Mental Health Care Program At A Glance "chart for details.

See "MMHC Precertification" for information about penalty for failure to precertify mental health/substance use admissions.

MMHC Out-of-Pocket Maximum

Managed Mental Health Care charges apply to the out-of-pocket maximum under the IBM PPO, IBM PPO Plus, IBM PPO with HSA, IBM Enhanced PPO with HSA and IBM EPO options and are shared with medical. Once a participant reaches the plan's out-of-pocket maximum (medical, mental health/substance use or a combination of the two) or the family out-of-pocket maximum is reached, remaining mental health/substance use services will be covered at 100%.

MENTAL HEALTH PLAN ADMINISTRATOR

All mental health/substance use claim payments and member services are handled by the Managed Mental Health Care Program administrator. As claims payer, the Mental Health Care Program administrator is responsible for:

- All claims processing, including coordination of benefits and application of U&P rates within industry standards.
- Maintaining the provider network.
- Managing and certifying benefit reimbursement for treatment under the IBM PPO, IBM PPO Plus, IBM PPO with HSA, IBM Enhanced PPO with HSA, and IBM EPO plan options.
- Managing care to assure appropriateness of treatment.

Mental Health Plan Administrator's Clinical Staff and Ongoing Reviews

The mental health plan administrator employs licensed mental health/substance use-disorder clinicians to assist you, authorize and manage the ongoing treatment plan for you. The clinical team includes Life Resource Counselors and Care Advocates. The clinical staff does not provide treatment directly to you but rather coordinate, direct and evaluate ongoing care. The clinical staff help you navigate the mental health/ substance use health care system, continue to provide you with guidance and have ongoing contact with providers and facilities who deliver care to ensure adherence to current treatment plans.

The clinical team employed by the administrator will contact you to discuss treatment, and assist in identifying other services covered under the IBM benefit plans that may be appropriate for you (e.g. financial counseling, legal services, medical referrals, etc.) Also, you are encouraged to contact the clinical team should you have any concerns you wish to discuss. The clinical team will communicate with your provider periodically to assess progress toward stated goals and need for continuing care for all in-network care. Care will continue to be certified in segments at the appropriate level for the length of time it is determined to be medically necessary and clinically appropriate by the administrator.
Out-of-network care is subject to medical necessity review by the mental health plan administrator. You will be responsible for 100% of charges for treatment determined not to be medically necessary, or for care rendered at an ineligible facility.

Care will not be paid by the Plan if it does not meet criteria for precertification, if you are not eligible under the MMHC benefit at the time services are rendered or if benefits are exhausted.

Confidentiality

The mental health plan administrator maintains the confidentiality of all patient-specific clinical information received from patients, their family members and their health care providers. Confidential information will not be disclosed to IBM or others without your express written consent except when required by law or to a third party contracted by IBM to review the program practices, including its clinical records to evaluate the administrator. When the employee or their dependents utilize their mental health benefit, the member who uses services will receive copies of letters, which certify or deny reimbursement and the employee will receive copies of claims explanation of benefits/payment.

If you contact IBM with a concern about a claim or an appeal, IBM must have access to the relevant information necessary to review the concern. In order for IBM to receive information regarding utilization of services and/or treatment, the patient or legal guardian must give written permission to investigate the concern, which means IBM will have the right to review copies of relevant documents generated in response to a certification request or benefit claim (e.g., certification letters and forms, denial letters and Explanation of Benefits [EOB] statements). For information about appealing denied benefits, see "Appeals" in the "Legal Information" section.

RELATIONSHIP TO THE IBM SPECIAL CARE FOR CHILDREN ASSISTANCE PLAN

The IBM Special Care for Children Assistance Plan is a separate program focused on the developmental problems of children with mental, physical, or developmental disabilities. The Managed Mental Health Care Program focuses on the treatment of diagnosed mental health and substance use problems. See "IBM Special Care for Children Assistance Plan" for details.

IBM Managed Pharmacy Program

IBM Managed Pharmacy Program

ABOUT YOUR PRESCRIPTION DRUG COVERAGE

The IBM Managed Pharmacy Program is designed to help you control medical costs by providing you and your eligible family members with specially-negotiated prices on prescription medications at participating network pharmacies and through a mail-order service. The IBM Managed Pharmacy Program is administered by CVS Caremark.

When you buy prescription drugs, you will pay a percentage of the cost, up to a per-prescription maximum dollar limit. Limits vary by Plan and whether you purchase a generic or brand-name drug. If your doctor prescribes medicines from a list of preferred brand-name and generic medications, called the Formulary Drug List, you will pay a lower percentage of the cost than if you purchase non-formulary drugs. There is no annual deductible under the IBM Managed Pharmacy Program except for those members enrolled in the IBM PPO with HSA, IBM Enhanced PPO with HSA plan option.

Per prescription maximums apply for traditional and specialty medications under the IBM Managed Pharmacy Program. Per prescription maximums refer to the maximum amount you will pay for a 30-day or 90-day supply. Specialty medications are those that require special handling or administration, such as chemotherapy and generally must be ordered through CVS Caremark's specialty care pharmacy. In most cases, traditional medications do not require special handling.

The per prescription maximums are shown under *"IBM Managed Pharmacy Program At-A-Glance."*

For all plan options, the amounts you pay out-of-pocket for eligible covered medications accumulate to your out-of-pocket maximum along with your eligible covered medical and mental health/substance use out-of-pocket costs. If you are enrolled in the IBM PPO with HSA or the IBM Enhanced PPO with HSA plan option, you must meet your deductible before the IBM Managed Pharmacy Program will begin to pay benefits (except for certain preventive medications). The deductible accumulates towards your out-of-pocket maximum. If more than one person is enrolled, you must meet the family deductible before the Plan begins to pay benefits.

Effective January 1, 2019, the Plan will not pay benefits for prescriptions purchased from an out-of-network pharmacy except those purchased while traveling outside the US. The majority of pharmacies in the US participate in CVS Caremark's pharmacy network. Visit www.caremark.com or call CVS Customer Care to find a participating pharmacy.

For generic medications, at a participating retail pharmacy or through mail order, you will pay the coinsurance, up to the generic per prescription maximum for both traditional and specialty drugs.

IBM continues to offer *GenericsAdvantage,* which is designed to help you take advantage of cost-saving alternatives to brand-name prescription drugs. If you fill a new prescription with a brand-name drug when a generic with the identical active ingredient (called a generic equivalent) is available, you will pay the generic coinsurance plus the difference in cost between the brand-name drug and the generic drug. (The generic per prescription maximum will not apply as it usually would for CVS Caremark participating pharmacies and mail-order prescriptions.) This additional cost will apply even if your doctor has indicated "DAW" ("dispense as written") on the prescription and does not apply to your out-of-pocket maximum.

If your doctor believes that there is a medical reason for you to use the brand-name drug instead of the generic and if you want to avoid paying the additional cost, your doctor can request a review by calling

800-294-5979, Monday through Friday, 9:00 a.m. to 7:00 p.m., Eastern time. If the review is approved, you will pay the usual brand-name coinsurance.

GenericsAdvantage has a feature for some brand name drugs. In some cases where a particular brand name drug is comparably priced with a generic in the same class of drugs, prior authorization will not be required for that brand drug. Prior authorization will still be required for other brand name drugs in that class; otherwise they will not be covered. Members impacted by this feature will receive communication from CVS Caremark as new drugs are added.

The eligibility of a prescription medication is subject to the terms of the IBM Managed Pharmacy Program, whether purchased at a participating or non-participating pharmacy. Covered and excluded medications under the Managed Pharmacy Program are defined later in this section.

There are three ways to purchase prescription drugs:

- At a CVS Caremark-participating retail pharmacy
- Through the CVS Caremark mail order pharmacy and
- Through a CVS retail pharmacy (CVS Pharmacy) under Maintenance Choice®

IBM MANAGED PHARMACY PROGRAM ADMINISTRATOR

The IBM Managed Pharmacy Program is administered by CVS Caremark.

Customer Service Availability
Representatives are available to assist you with claim questions or other inquiries 24 hours a day, 365 days a year. You can reach CVS Caremark Customer Care at 855-465-0030 TTY: 800-863-5488. The CVS Caremark website is www.caremark.com.

For the fully-insured HMOs, the health plan is the administrator for prescription drug benefits.

Who Is Eligible
All regular full-time and regular part-time employees, long-term supplemental employees, retiree supplemental employees and their eligible family members who are enrolled in the IBM PPO, IBM PPO Plus, IBM PPO with HSA, IBM Enhanced PPO with HSA, or the IBM EPO plan option are automatically covered under the IBM Managed Pharmacy Program. Employees enrolled in a fully-insured HMO, or in the IBM Global Assignee Medical Plan are not eligible to use this program, prescription coverage is available through the corresponding medical plan.

ID Card
If you are eligible for the IBM Managed Pharmacy Program, you will receive a set of ID cards for prescription drug coverage. The ID cards contain a unique member ID number — which is not your Social Security number. To ensure pharmacy benefit coverage use your card when purchasing drugs from participating retail pharmacies or through the CVS Caremark mail order pharmacy, when calling Customer Care or accessing the CVS Caremark web site. You can order additional ID cards by visiting www.caremark.com, using the Caremark App or calling CVS Caremark Customer Care.

The IBM Managed Pharmacy Program ID cards are in the name of the primary covered person. In most cases this will be the active employee. Exceptions are ID cards for domestic partners and surviving spouses.

IBM MANAGED PHARMACY PROGRAM AT-A-GLANCE

	Participating Retail Pharmacies (up to 30-day supply)	CVS Caremark Mail Service, Specialty Pharmacy or Maintenance Choice (up to a 90-day supply)
You Pay:		
Traditional and Specialty* medications for the IBM PPO with HSA and IBM Enhanced PPO with HSA		
Generic	10% of discounted cost after deductible[1], up to $20	10% of discounted cost after deductible[1], up to $40
Preferred Brand	30% of discounted cost after deductible[1], up to $115**	30% of discounted cost after deductible[1], up to $290**
Non-Preferred Brand	50% of discounted cost after deductible[1], up to $220**	50% of discounted cost after deductible[1], up to $525**
Traditional and Specialty* medications for the IBM PPO, IBM PPO Plus and IBM EPO		
Generic	10% of discounted cost, up to $20	10% of discounted cost, up to $40
Preferred Brand	30% of discounted cost, up to $115**	30% of discounted cost, up to $290**
Non-Preferred Brand	50% of discounted cost, up to $220**	50% of discounted cost, up to $525**
* Specialty Medications - Prescription medications that require special handling or administration (such as chemotherapy) must be ordered through CVS Caremark Specialty Pharmacy. You may be able to have the medication shipped to you or your doctor's office at no additional charge.		
** Generics Advantage - If a generic with the identical active ingredient is available, and you choose the equivalent brand name drug instead, you will pay the generic coinsurance PLUS the difference between the generic and applicable brand name drug; per prescription maximums will not apply.		
Features		
Prescription Supply	Up to a 30-day supply	Up to a 90-day supply
Retail Pharmacies	Coverage only provided if purchased from CVS Caremark pharmacies or pharmacies in their retail network.	Coverage only provided if purchased from CVS Caremark pharmacies or pharmacies in their retail network.
When to Use	For short-term, immediate medication needs (up to three fills)	For long-term, maintenance medications and specialty medications
Claim Forms	Claim filed automatically when you use your ID card at a participating pharmacy; you must file a claim if you do not present your ID card	Claim filed automatically
[1]Prescription drug charges (except for preventive medications) are subject to the annual medical deductible and apply toward the annual medical out-of-pocket maximum. If more than one person is enrolled, the family deductible must be met before the plan will provide coverage for non-preventive medications. The deductible does not apply to preventive medications. A list of medications is available on www.caremark.com.		

PREVENTIVE CARE SERVICES BENEFIT

IBM's Managed Pharmacy Program follows guidelines set by the US Preventive Services Task Force and allows certain preventive medications to be available to you at no cost. These include certain immunizations, contraceptive products and tobacco cessation products. The CVS Caremark Preventive Drug List can be found on www.caremark.com or by calling CVS Caremark Customer Care.

IBM PPO WITH HSA AND IBM ENHANCED PPO WITH HSA PREVENTIVE DRUG BENEFIT

The IBM PPO with HSA and IBM Enhanced PPO with HSA plan options have a high deductible health plan (HDHP) preventive drug benefit applicable to those drugs listed on the CVS Caremark HDHP Preventive Drug List, which differs from the Preventive Care Services benefit. Enrollees in this option will pay the usual coinsurance for preventive medications (those used to prevent a condition from occurring), even if the plan's deductible has not been met. The list of drugs considered preventive for the HDHP plan options is available online at www.caremark.com or by calling CVS Caremark Customer Care.

The CVS Caremark HDHP Preventive Drug List is designed to comply with the safe harbor established in the Internal Revenue Code for high deductible health plans that cover preventive care prior to satisfaction of a deductible (Preventive Care Safe Harbor) 26 USC § 223(c)(2). It is based on guidance issued by the United States Department of the Treasury (Treasury), Internal Revenue Service (IRS) in Notices 2004-23, 2004-50 and 2013-57 (Treasury Guidance). Under the Treasury Guidance, a drug or medication is regarded as preventive if it meets any one of the following criteria:

- It is taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic). For example, the treatment of high cholesterol with cholesterol-lowering medications such as statins to prevent heart disease.
- It is used to prevent the reoccurrence of a disease from which a person has recovered. For example, the treatment of recovered heart attack or stroke victims with angiotensin-converting enzyme (ACE) inhibitors to prevent a reoccurrence.
- It is used as part of procedures providing preventive care services specified in Treasury Notice 2004-23, including obesity weight-loss and tobacco cessation programs.
- It is included in the preventive health services required to be covered with no cost-sharing under Section 2713 of the Public Health Service Act and any implementing regulations or guidance.

RETAIL PHARMACY PROGRAM

You may purchase up to a 30-day supply of covered medication from a participating retail pharmacy. There is no coverage for prescriptions filled at pharmacies that do not participate in CVS Caremark's retail network. You can fill prescriptions for long-term medications up to three times at a retail pharmacy — your initial prescription plus two refills, for a total of three fills of your medication. This is not an annual limit. After that, you generally must order your prescription through the CVS Caremark mail-order program or obtain a 90-day supply at a retail CVS Pharmacy, or you will pay 100% of the cost yourself.

Under CVS Caremark's Maintenance Choice program, participants can receive their 90-day prescriptions for maintenance medications through the mail or at one of the CVS Pharmacy retail locations nationwide for the same price as mail order. *Note: This option is only available at retail CVS Pharmacy locations.*

Medications that are exempted from the mail-order program requirement are Schedule 2 Controlled Substances, such as narcotics or drugs used to treat Attention Deficit Disorder, and compound medications. These types of medications can be purchased at a retail pharmacy even if you take them on a long-term basis, subject to the 30-day limit. Patients in nursing homes are also exempt from the mail-order program requirement. However, you must contact CVS Caremark to establish the exemption.

A NOTE ABOUT FORMULARY DRUGS

You will pay a lower percentage of the cost if your doctor prescribes a medication from this list of preferred drugs. You'll still be able to purchase non-preferred brand name medications but you will pay a greater share of the cost. For more information about the formulary, or to learn which drugs are preventive or require prior authorization or Step Therapy, sign into www.caremark.com or download the CVS Caremark app or call CVS Caremark Customer Support at 855-465-0030.

Participating Network Pharmacies

CVS Caremark contracts with a large network of chain and independent pharmacies across the United States. These pharmacies agree to accept specially-negotiated prices on prescription drugs. When you and your eligible family members use a participating pharmacy and show your pharmacy ID card, there are no claim forms to file. All you have to do is pay your portion of coinsurance; those enrolled in a plan option with an HSA will need to satisfy the deductible before the Plan will pay benefits. Generally, the amount you pay for your medication applies to your annual out-of-pocket medical plan maximum.

To find a participating pharmacy in your area, log in to www.caremark.com or call CVS Caremark Customer Care. Individuals who live in an area without convenient access to a network pharmacy can ask their pharmacist to call CVS Caremark Customer Care to get information about joining the network.

How to Fill Your Prescription Under the Retail Program

When you need to fill a prescription at a participating retail pharmacy, simply follow these steps:

- Present your ID card to the pharmacist before the prescription is dispensed to ensure that your claim will be processed automatically and that you will be charged the correct coinsurance amount.
- Pay the pharmacist for your portion of the prescription at the time of purchase.
- If you fill a new prescription with a brand-name drug when a generic with the identical active ingredient (called a generic equivalent) is available, you will pay the generic coinsurance plus the difference in cost between the brand-name drug and the generic drug. This additional cost will apply even if your doctor has indicated "DAW" ("dispense as written") on the prescription and does not accumulate to your out-of-pocket maximum.

If You Don't Use Your ID Card at a Participating Pharmacy

You should present your ID card to the pharmacist when you purchase your medication, so they can confirm your eligibility for prescription coverage with CVS Caremark. If you do not have your ID card, you may ask the pharmacist to contact CVS Caremark to confirm your eligibility. If you do not show your ID card and they cannot confirm your eligibility, you can pay for the prescription in full and submit a claim form to CVS Caremark for reimbursement. Your reimbursement will be based on the negotiated price for the applicable type of medication (generic/formulary brand-name or non-formulary brand-name) and *not* the price you paid. To file a claim, follow the directions under "How to File a Claim for Non-participating Pharmacies."

Non-participating Pharmacies

If you choose to have a prescription filled at a pharmacy that does not participate in CVS Caremark's network (a non-participating pharmacy), you must pay 100% of the pharmacy's actual charge at the time you receive your medication. The Plan will not provide benefits for these expenses.

MAIL ORDER PHARMACY PROGRAM

The CVS Caremark Mail Order Pharmacy home-delivery program provides a convenient, cost-effective way to purchase long-term prescription medications. If you have a chronic condition, such as high blood pressure, high cholesterol, heart conditions, arthritis, ulcers, asthma and diabetes, you should use the

mail program to purchase your long-term prescriptions. Through the mail-order program, you may receive up to a 90-day supply of the prescription medication. Orders will be delivered by mail, postage paid, anywhere in the United States. You can request expedited shipping (for an additional fee) at the time you place your order.

Please note that you can use the CVS Caremark Mail Order pharmacy and receive up to 90 days of medication or you can get your 90-day supply at a retail CVS Pharmacy through Maintenance Choice. All other mail service programs, such as AARP and online pharmacies, if part of the CVS Caremark pharmacy network, will be treated as retail pharmacies and only 30 days of your medication will be reimbursed, even if you purchase a greater quantity.

IF YOU TRAVEL OUTSIDE THE U.S.

If you are planning on being out of the country for an extended period of time and you need an additional supply of medications before you leave the country, the Managed Pharmacy Program allows for a vacation supply of medication (up to 60 days through retail and 180 days through the mail program). Additional supplies beyond 60 days are only covered through the mail-order program. If you are using the mail-order program for the first time, you should allow for up to 14 days for delivery after receipt of your prescription by the mail-order pharmacy.

There are no participating pharmacies located out-side the U.S. Therefore, if you purchase medications while outside the U.S. you must submit a claim to receive reimbursement and will be subject to the following level of reimbursement. Drugs purchased outside the U.S. must have an exact American equivalent to be eligible for reimbursement. You will be reimbursed as follows:

- Generic medications: 30% of the full cost of the medication, up to a 30 day supply
- Brand name formulary medications: 40% of the full cost of the medication, up to a 30 day supply
- Brand name non-formulary medications: 50% of the full cost of the medication, up to a 30 day supply

***NOTE**: Not all medications can be taken or delivered into other countries. Please review limitations in the non-US country before leaving.*

How to Order New Prescriptions

- If you need your prescription immediately, and wish to obtain your long-term medication:
  - Your doctor may ePrescribe the prescription directly to a participating retail pharmacy. Be sure your doctor has your Member ID number, which can be found on your ID card.
  - Through mail order: Ask your physician to write two prescriptions — one for a 14-day supply to be filled at your retail participating pharmacy and a second to be filled by the CVS Caremark Mail Order Pharmacy (for up to a 90-day supply), with three refills.
  - At a local CVS Pharmacy: You can take advantage of the Maintenance Choice® feature and fill your 90-day prescription there (with up to three refills), often picking up the prescription the same day.
- Or, you may mail your original prescription or refill slips together with the completed order form and required payment to the Mail Order Pharmacy. If you mail more than one prescription in the same envelope, be sure to include the correct coinsurance amount for each. Order forms and envelopes are available from CVS Caremark Customer Care.
- Your mail account balance cannot exceed $300. Once you reach this limit, medications will not be shipped until you pay your balance.
- CVS Caremark will promptly process your order and send your medications, along with your invoice, to your home within approximately 14 days through U.S. Mail or United Parcel Service (UPS) along with instructions for refills. Medications requiring special handling will be shipped in accordance with established safety and security procedures. A signature may be required for certain medications. Check with CVS Caremark Customer Care at the time you order.

How to Order Refills

- You may reorder your prescription on or after the refill date indicated on the refill slip of your medication container or when you have used 75% of your medication for non-controlled substances. The refill threshold is set to 80% for controlled (CII) substances. At no time can you refill if you have more than 30 days of medication on hand (mail and retail fills combined). You may order refills online through www.caremark.com, by phone or by mail. You'll need your Member ID number, the prescription number, your credit card number and the expiration date to order a refill.
- To determine the amount of your payment, you can call CVS Caremark Customer Care or log in to www.caremark.com.
- You will need to provide the number of days' supply, dosage, strength, exact drug name and quantity.

Paying for Prescriptions Through the Mail-Order Program

You may pay your coinsurance by check, credit card, debit card, money order, e-check, Health Care Spending Account Health Debit Card or your Health Savings Account Debit Card (be sure to sign the mail order form if paying by credit card). If your physician ePrescribes or faxes the prescription to the Mail Order Pharmacy on your behalf, CVS Caremark will bill you later for your coinsurance unless you set up automatic payment. Note that if you have an outstanding mail account balance of $300 or more, CVS Caremark cannot ship your medication until you pay your balance. To set up automatic payment, simply provide your credit or debit card number on the mail order form and complete the applicable information. It is important to keep your contact information up to date on www.caremark.com. If your order exceeds $500, even if you have an automatic payment in place, CVS Caremark will contact you (using the contact information in your profile) for confirmation of the order before shipping the medication.

COMPOUND MEDICATIONS

Please note when purchasing a compound medication, claims are adjudicated using a different formula. Please contact CVS Caremark for specific details.

If you submit a paper claim for one of these medications, you will need to include an itemized list of each ingredient including its name, National Drug Code, price and quantity used. Formulary and non-formulary reimbursement levels apply. Formulary status is determined by the status of the largest component in the compound. There is a separate Compound Claim Form available from CVS Caremark.

Note

- all compound prescriptions greater than $300 in cost will require prior authorization
- costly proprietary topical compounding bases and bulk powders (that have not been proven to have additional benefits) will be excluded from coverage
- coverage for compounds will be limited to 30-day supplies

If the compound ingredients are not covered, you will be responsible for the full cost of the prescription. If the compound ingredients are covered through prior authorization, you will pay your usual cost share. This is particularly important to remember if the compounding pharmacy suggests you pay out-of-pocket for compounded prescriptions, then submit the claim through your benefit plan for reimbursement. Please be aware that these claims also will be subject to review, and reimbursement is not guaranteed.

CVS CAREMARK MAINTENANCE CHOICE®

Maintenance Choice® is a feature of the IBM Managed Pharmacy Program. You can continue to have your 90-day supply of medications shipped directly to your home through mail order, or you can pick them up at your local CVS Pharmacy retail location for the same coinsurance. The choice is yours.

All of the medications, with an 84- to 90-day supply that you currently order through mail service are eligible for this program.

If you take several long-term medications, you have the flexibility to receive some through mail and others at retail pick-up through your local CVS Pharmacy. You can transfer your mail-service prescriptions to your local CVS Pharmacy by calling Customer Care at 855-465-0030 or signing on to www.caremark.com.

If you need to obtain a new prescription, you can have the pharmacist at your local CVS Pharmacy contact your doctor for a 90-day prescription. You can also ask your doctor to ePrescribe (or call) the CVS Pharmacy with a 90-day prescription. Let the pharmacist know that your prescription benefit program includes the Maintenance Choice® feature.

Please note: some medications may not be eligible for 90-day supplies through Maintenance Choice due to state regulations, such as Schedule 2 Controlled Substances (e.g., narcotics or drugs used to treat Attention Deficit Disorder). Contact CVS Caremark Customer Care for more details.

COVERED MEDICATIONS

The following items are covered when prescribed by a physician and medically necessary:

- Federal legend drugs
- State restricted drugs
- Compounded medications of which at least one ingredient is a legend drug; *(Note: new coverage rules apply; please see "Compound Medications" for details)*
- Oral contraceptives, the contraceptive patch (Ortho EVRA), contraceptive devices and implants; contraceptive jellies, creams and foams with a prescription *(Note: Contraceptive devices and implants not available through the IBM Managed Pharmacy Program may be covered under the IBM Medical Plan.)*
- Insulin
- Needles and syringes
- Certain over-the-counter diabetic supplies with a prescription
- Retin-A and Avita cream through age 34 (may be eligible beyond age 34 with prior authorization)
- Legend prenatal vitamins
- Legend vitamin D and K
- Legend folic acid
- Hematinic vitamins and
- Legend vitamin B12/Cyanocobalamin.

Exclusions Under the Managed Pharmacy Program

- Non-federal legend drugs
- Topical fluoride products
- Yohimbine
- Allergy sera
- Therapeutic devices or appliances
- Drugs which are not considered medically necessary
- Drugs whose sole purpose is to promote or stimulate hair growth (for example, Rogaine, Propecia) or drugs for cosmetic purposes only (for example, Renova)
- Immunization agents and vaccines
- Blood or blood plasma

- Drugs labeled "Caution — limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows it to be operated on its premises, a facility for dispensing pharmaceuticals (covered under the IBM Medical Plan)
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- Medical devices and appliances
- Vitamins and minerals — except the following, which are covered: hematinics for the treatment of anemia, prenatal vitamins, legend folic acid, legend vitamin B12/Cyanocobalamin and legend vitamin D and K
- Over-the-counter medications, even when prescribed (except for certain diabetic supplies)
- Certain over-the-counter, non-essential medical supplies, including alcohol wipes and insulin pump batteries. For a complete list of excluded supplies, please contact CVS Caremark Customer Care
- Any other exclusions listed under "Exclusions: What the IBM Medical Plan Does Not Cover"
- Homeopathic, naturopathic treatments, minerals, nutritional supplements, dietetic foods, etc.
- Prescription drugs for which there is an over-the-counter equivalent available in the same strength and preparation, such as meclizine and ranitidine (Contact CVS Caremark Customer Care for a complete list)
- Drugs purchased in foreign countries which do not have an exact American equivalent and
- All medications in the Proton pump inhibitor class (generic and brand-name), such as lansoprazole, omeprazole, pantoprazole, Aciphex, Dexilan, Nexium and Zegerid for patients 18 years of age and older
- Bulk chemicals which have not been determined to be safe and effective or medically necessary for topical administration (Contact CVS Caremark Customer Care for a complete list)
- Nasal steroids

FORMULARY DRUG LIST

The IBM Managed Pharmacy Program uses the CVS Caremark formulary drug list. A formulary is a list of commonly prescribed medications that have been shown to be clinically effective as well as cost effective. If your doctor prescribes formulary medications, you can help control rising health care costs while still maintaining high-quality care. The Formulary Drug List is available online at www.caremark.com or by calling CVS Customer Care.

The CVS Caremark formulary drug list is reviewed and updated on a quarterly basis. When a generic equivalent becomes available for a brand medication, that brand medication is automatically removed from the formulary. Additionally, products with egregious cost inflation that have readily-available, clinically-appropriate and more cost-effective alternatives may be evaluated and potentially removed from the formulary.

Because the formulary list is subject to change, you should consult CVS Caremark before filling a prescription to ensure you have the most current information.

If you choose to purchase a brand medication not on the formulary, you will be responsible for paying a higher coinsurance. If there is a clinical reason why you cannot take the formulary medication, you can request an appeal through CVS Caremark by calling Customer Care. If the appeal is approved, you will only be charged the formulary coinsurance. This approval is valid for as long as you are taking the prescription.

Under the IBM Managed Pharmacy Program there may be times when you use a participating pharmacy and are filling a prescription with a non-formulary brand-name drug. The pharmacist will receive a message stating the status of the medication is non-formulary (or non-preferred). Your retail pharmacist may decide to discuss with your physician whether an alternative drug listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. If you prefer to have the originally-prescribed medication, you have the option to refuse the alternative medication before it is filled and to request the pharmacist fill the prescription as it was originally written. However, you will be responsible for paying the higher, non-formulary brand-name coinsurance.

When you order through the mail-order program, the pharmacist may also decide to discuss with your physician whether an alternative medication listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative medication and a confirmation letter will be sent to you and your physician explaining the change.

Let your physician know if you have any questions about a change in prescription. Your physician always makes the final decision about what medication to prescribe for you.

GENERIC DRUGS

Generic-equivalent medications contain the same active ingredients and are subject to the same rigid Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generally, generic drugs cost less than brand-name drugs because they don't require the same level of sales, advertising and development which are expenses associated with brand-name drugs.

Under the IBM Managed Pharmacy Program, CVS Caremark will periodically review medications and if there is a generic available for the brand-name medication you are currently using, you may receive a letter advising you of the generic availability.

GenericsAdvantage is a voluntary program and if you prefer to continue using the brand-name drug you may do so. Your doctor should write Dispense as Written (DAW) on the prescription to prevent a switch being made. Please note the specifics of this requirement may vary by state. Check with your doctor. If you switch to a generic medication your coinsurance will be based on the generic price. If you remain on the brand name drug, your coinsurance will be based on the *GenericsAdvantage* cost share provisions described previously. Additionally, the amount you pay out-of-pocket equal to the difference in price of the brand and generic medications will not accumulate to your deductible or out-of-pocket maximum.

For certain therapeutic classes, you may be required to try generic medications before the plan covers more expensive brand-name alternatives. This will apply even if you have been taking the brand-name medication for some time. Please contact CVS Caremark Customer Care for a complete list of drugs in this Generic Step Therapy Program.

If you switch to a generic medication your coinsurance will be based on the generic price. If you choose to stay on the brand-name medication, you will have to pay the medication's full price if you have not tried the generic option(s) available to treat your condition. If your doctor feels you have a unique medical

situation that requires you to keep taking the brand-name medication, ask him or her to call CVS Caremark at 877-203-0003 to request prior authorization.

Please note for all brand-name drugs not on the Generic Step Therapy Program list, unless your doctor writes "Dispense as Written" on your prescription, state laws may permit (or require) the pharmacist to substitute a generic version of the prescribed drug if all prescription requirements are met.

DRUG MANAGEMENT PROGRAMS

Prior Authorization Program

The IBM Managed Pharmacy Program provides coverage for some medications only if they are prescribed for certain uses. These medications must receive "prior authorization" before they can be covered under the IBM Managed Pharmacy Program. The list of drugs requiring prior authorization changes periodically. If you have a question on drug coverage, please call CVS Caremark Customer Care.

If you require a new prescription for a specialty medication, your doctor will first need to contact CVS Caremark for authorization to confirm the treatment complies with standard clinical guidelines. This requirement will help ensure you receive the proper drug, dose and treatment based on your diagnosis.

If the medication prescribed for you requires prior authorization, ask your physician to call the Authorization Unit at CVS Caremark for instructions on how to initiate the review process. You can obtain the phone number by calling CVS Caremark Customer Care. Otherwise, if you take a prescription for one of these medications to a participating pharmacy without prior approval, the pharmacist can initiate the review process on your behalf, or will provide you with the telephone number for your doctor to call. This process typically takes two business days to complete. You and your physician will be notified by mail when the review process has been completed.

If your medication is not approved for coverage under the IBM Managed Pharmacy Program, you will be responsible for paying the full cost of the drug.

CVS Specialty Pharmacy

If you need covered prescription medications that require special handling or administration, like chemotherapy drugs, you will need to order them through CVS Specialty Pharmacy or the CVS Site of Care Program, part of the IBM Managed Pharmacy Program. By receiving covered prescription medications this way, you may pay less for them overall. Additionally, you may be able to have them shipped directly to you or your doctor's office at no additional charge. Contact CVS Specialty Customer Service at 888-346-6578 to transfer a prescription or obtain more details.

Note: specialty drugs purchased at a retail pharmacy will not be covered. All specialty drugs must be obtained through the CVS Specialty Pharmacy except as follows:

- *Specialty medications provided by your medical provider that are billed as part of your office visit*
- *If a medication's manufacturer has an exclusive arrangement with a specialty pharmacy other than CVS Caremark, that pharmacy will fulfill your medication instead of CVS Specialty Pharmacy and you will have coverage under the Plan.*

In addition, CVS Specialty's Drug Step Therapy program promotes the use of safe, equally effective, and lower-cost preferred medications before using a higher-cost, non-preferred medication. You will be required to try the preferred medication first. If you decide to take the non-preferred medication without trying the preferred, you will have to pay the full price for the non-preferred medication. This rule covers drugs to treat rheumatoid arthritis, multiple sclerosis, and infertility.

Keep in mind, some specialty medications require a clinical review to be used for continued treatment or when they are first prescribed. Contact CVS Caremark Customer Care for more information.

The IBM Managed Pharmacy Program includes CVS Caremark's Specialty Guideline Management Program. For continued coverage of a medication in this program, a clinical review is required. CVS Specialty will obtain the necessary clinical information from your doctor's office and conduct the review. There is a chance the review will identify other options for treating your condition. If so, you and your doctor will be notified.

Manufacturer's Coupons

There are times when you can decrease your copayment for a prescription drug by using a manufacturer coupon for copay assistance. Note that you cannot use manufacturer coupons when purchasing traditional medications through CVS Caremark mail order, and often cannot use them when you purchase medications through Maintenance Choice at your retail pharmacy. However, CVS Specialty mail order does accept manufacturer coupons, and they will assist you to find available coupons from the manufacturer for your medication.

Note that if you are enrolled in the IBM PPO, IBM PPO Plus or IBM EPO plan option and you use a manufacturer's coupon to purchase a specialty medication:

- The amount of the coupon which is applied to your copay does not accumulate to your out-of-pocket maximum, and
- If the amount of the manufacturer's coupon exceeds the amount of your copayment for a given medication, CVS Caremark will adjust the copay amount to get the most value out of the coupon; however, you will still be responsible for the same post-coupon copayment.

Infusion Therapy

Certain infused specialty therapy medications (e.g., Remicade and IVIG drugs), are covered under the IBM Managed Pharmacy Program and obtained through CVS Specialty Pharmacy. CVS Specialty Pharmacy will work with you and your physician to deliver your medication to where it is being administered such as your home or a cost-efficient outpatient infusion center. Note that this excludes chemotherapies, except Blincyto.

Dose Optimization Program

Certain long-term medications will be covered by the IBM Managed Pharmacy Program's dose optimization feature, which makes prescriptions available in a more convenient dosing regimen. For example, you may be taking a 50 mg dose of a certain medication two times a day when there may be a 100 mg dose of the same medication that can be taken once a day.

Changing to one dose each day, when appropriate, can result in greater convenience and lower costs for participants. CVS Caremark will contact your doctor and ask if dose optimization is right for you. If your doctor approves, you will receive the optimized dose.

Drug Utilization Review — Safe and Appropriate Use of Medications

By continually using participating pharmacies or by using the mail-order pharmacy, you also gain the advantage of a prescription review. This confidential online system allows the pharmacist access to important information, such as your individual drug history, the possibilities of interaction among various drugs and how long it has been since your last prescription was filled. If the potential for drug-related illness or incompatibility is flagged, an alert message is sent to the pharmacist who can then inform you to check with your doctor or make a professional judgment whether to dispense your prescription.

Under the IBM Managed Pharmacy Retail Program there is a "refill-too-soon" feature which does not allow a refill of medication until 75% of the original prescription has been used for non-controlled substances. The refill threshold is set to 80% for controlled (CII) substances. This feature helps to prevent overuse of medication and purchase of more medication than is necessary. Additionally, under the mail-order program your refill slip will indicate your earliest refill date. If you request a refill before the earliest refill date, your refill request will be held and sent on the appropriate refill date.

There is also a coverage management program which has established appropriate threshold levels of utilization (e.g. limit on number of doses) for specific drug therapy categories and payment will be rejected at the point of sale (retail or mail) whenever the drugs being dispensed exceed those predetermined limits or if you do not meet the clinical criteria to receive the medication (determined by the prior authorization review).

COORDINATION OF BENEFITS

It is a requirement under the Plan to provide information regarding any other coverage they may have. If there is an indication that there is other primary coverage, payment in full will be required at the time of purchase from a retail pharmacy and from the mail-order program. You must first file a claim with the primary plan. When you receive the Explanation of Benefits (EOB) statement from the primary plan, fill out the IBM Managed Pharmacy Claim Coordination of Benefits/Out-of-Network Claims form and attach a copy of the EOB and your receipt and mail these documents to CVS Caremark at the address on the form. Your claim will be processed according to the Plan's coordination of benefits provisions. See "Coordinating Coverage" in the Administrative Information section.

If the primary coverage is also a card program, you should attach your receipt to a copy of the claim form and mail to CVS Caremark for consideration of any additional benefit.

Special rules apply for coordination with Medicare Part D prescription drug plans. See "Coordinating IBM Medical Coverage with Medicare."

OTHER IMPORTANT INFORMATION

Other features of the IBM Managed Pharmacy Program include keeping a profile of your medication history and providing a toll-free number to speak with a pharmacist.

Prescription information of employees and their dependents is used by CVS Caremark and its affiliates to administer the IBM Managed Pharmacy Program. As part of this administration, CVS Caremark generally reports that information to the administrator of the IBM medical plan option that you selected, and your Medical Plan administrator reports your medical information to CVS Caremark. Your prescription and medical data is used to identify potential overuse, abuse and waste of particular medications as well as appropriateness of the medications prescribed. CVS Caremark may send alerts to prescribing physicians and dispensing pharmacists about the situations it identifies. CVS Caremark also uses the prescription data gathered from claims submitted nationwide for reporting and analysis without identifying individual patients.

CVS Caremark may also take other actions to address concerns it identifies with utilization of the IBM Managed Pharmacy Program, including limiting you to the use of one retail pharmacy if your pattern of utilization for a particular medication warrants it.

IBM Dental Coverage

IBM Dental Coverage

ABOUT YOUR DENTAL BENEFITS

IBM's dental coverage offers you a choice of options, from basic dental coverage for preventive and basic restorative care to more comprehensive dental coverage. Your personalized Health Plan Detail Sheet will reflect the options available to you.

IBM's two dental options:

- **IBM Dental Basic option** — provides basic coverage for preventive, diagnostic and basic restorative care only, up to a $500 annual benefit limit per covered person.
- **IBM Dental Plus option** — offers you the opportunity to increase your dental benefits to cover more extensive dental treatment, including preventive, diagnostic, basic restorative, major restorative and orthodontia care. Benefits under the Dental Plus option are limited to $2,000 per covered person per year; orthodontia care is limited to a lifetime maximum up to $2,500 per covered person.

A summary of dental benefits is provided below. For detailed information on covered services and procedures please refer to the MetLife Dental Certificate of Insurance and CDT Code Procedure Type List available on www.metlife.com/mybenefits. To verify coverage and for information on any specific procedure, you should contact a MetLife customer service representative.

IBM DENTAL BASIC AND IBM DENTAL PLUS ADMINISTRATOR

The IBM Dental Basic and Dental Plus options are administered by MetLife.

Customer Service Availability
Representatives are available to assist you with claim questions or other inquiries Monday through Friday from 8:00 a.m. to 11:00 p.m., Eastern time. The Voice Response Unit (VRU) for claims inquiries is available 24 hours a day, 7 days a week.

You can reach MetLife at 800-872-6963 (TTY: 800-843-2896) or www.metlife.com/mybenefits

Who Is Eligible

All regular full-time and regular part-time employees and their eligible family members are eligible for the IBM Dental Basic and IBM Dental Plus options.

If you and your eligible family members are living outside of the U.S. and Puerto Rico, you will be eligible for dental benefits reimbursement for eligible services but at the out-of-network level only since there are no network providers outside of the U.S. and Puerto Rico.

Employees enrolled in the IBM Global Assignee Medical Plan will receive their dental coverage through Cigna Global Health Benefits.

ID Card

If you enroll in the IBM Dental Basic or IBM Dental Plus options, you will receive an ID Card, which will remain good for as long as you are enrolled in the IBM Dental Basic or IBM Dental Plus options. New cards will not be sent each year. If your card is lost or damaged, call MetLife member services to request a replacement card or log onto www.metlife.com/mybenefits to print one.

IBM DENTAL PLAN COVERAGE AT-A-GLANCE

IMPORTANT NOTE

If there is a discrepancy between the information in this section and the certificate of coverage for this plan, the terms of the certificate will govern.

For a copy of the certificate of coverage, or if you have questions, you can reach MetLife at 800-872-6963 (TTY: 800-843-2896) or www.metlife.com/mybenefits

	IBM Dental Basic		IBM Dental Plus	
Annual Deductible				
In-Network	None		None	
Out-of-Network	None		None	
Annual Maximum Benefit	$500 per covered person		$2,000 per covered person[1]	
Lifetime Maximum Benefit	No limit		No limit	
Orthodontia Lifetime Maximum	Not applicable		Up to $2,500 per covered person	
Level of Care	**The Plan Pays**			
	In-Network	***Out-of-Network[2]***	***In-Network***	***Out-of-Network[2]***
	Out-of-Network[2]		***Out-of-Network[2]***	
Preventive Treatment ▪ Routine oral exams ▪ Routine cleanings ▪ X-rays ▪ Fluoride treatments ▪ Space maintainers ▪ Sealants	100% of the negotiated fee for eligible charges	100% of U&P rate	100% of the negotiated fee for eligible charges	100% of U&P rate
Basic Restorative Treatment[4] ▪ Amalgam and composite fillings	80% of the negotiated fee for eligible charges	80% of U&P rate	80% of the negotiated fee for eligible charges	80% of U&P rate
Major Restorative Treatment[4] ▪ Crowns and bridgework ▪ Dentures ▪ Extractions ▪ Implants[3] ▪ Inlays and onlays ▪ Oral surgery that is dental in nature ▪ Periodontal services, including periodontal scaling and root planing ▪ Endodontics, including root canals	Not covered	Not covered	65% of the negotiated fee for eligible charges	65% of U&P rate

	IBM Dental Basic		IBM Dental Plus	
Orthodontia ▪ Examinations ▪ Diagnostic procedures ▪ Appliances, including removable, fixed and minor or intermediate appliances	Not covered	Not covered	50% of the negotiated fee for eligible charges	50% of billed fee rate

[1]Orthodontic charges do not count towards the annual maximum benefit.

[2]You are responsible for 100% of any charges above the U&P rate.

[3]A pretreatment estimate is recommended for implants and implant-related services before work is done.

[4]There are replacement and frequency limitations for some services. Contact the administrator of your dental option for details.

Usual and Prevailing (U&P) Rate

The usual and prevailing rate for out-of-network dental services is defined as the maximum fee taking into consideration the following:

- The fee that an individual dentist most frequently charges the majority of patients for a similar service or dental procedure.
- The range of usual fees charged for the service or procedure by dentists for the performance of a similar service or dental procedure within the same locality.
- Special circumstances or complications requiring additional time, skill and experience in connection with that particular dental service or procedure.

MetLife shall determine U&P rate information in all cases. Keep in mind the U&P rate may be different than the amount charged by an out-of-network dental provider. If the charge for services is more than the U&P rate set by the Plan, you will have to pay your provider the amount that exceeds the U&P rate, in addition to the applicable deductible and coinsurance.

QUALITY CARE INITIATIVE

IBM and the IBM Dental Plan participate in various programs that are designed to encourage health care providers to deliver efficient, safe, effective quality care to IBM employees and retirees and their spouses and dependents. Under these programs, health care providers who are determined to employ recommended practices in their administration of health care generally are rewarded through per capita incentives paid from the Plan's trust as additional fees for services provided. IBM employees and retirees are not responsible for payment of the quality care incentives.

HOW THE IBM DENTAL PLAN WORKS

Under the IBM Dental Basic and IBM Dental Plus options, you can visit any licensed dentist of your choice, but you will receive the highest level of coverage when you obtain services from a dentist who is a member of MetLife's network.

IF YOU SWITCH FROM THE IBM DENTAL PLUS TO THE IBM DENTAL BASIC OPTION

If you change your enrollment from the IBM Dental Plus option to the IBM Dental Basic option during annual enrollment or in the middle of the year due to a qualified status change, dental treatment "in progress" at the time of your enrollment change will become ineligible for coverage 60 days after your IBM Dental Plus option coverage ends unless the services continue to be eligible under the IBM Dental Basic option.

For example, if your child is receiving orthodontia treatment under the IBM Dental Plus and you change enrollment to the IBM Dental Basic, that treatment will no longer be covered since orthodontia care is not a covered service under the IBM Dental Basic option.

The applicable annual maximum carries over to/ from Dental Basic and Dental Plus when plan changes occur during the same calendar year. For example, if you make a mid-year plan change to Dental Basic from Dental Plus and you've already used $200 towards your annual maximum under Dental Plus, you will have $300 remaining towards your new annual maximum under Dental Basic ($500) for the remainder of the plan year.

In-Network Providers

You can take advantage of negotiated rates when you receive treatment from a participating MetLife network dentist. Plus, your network dentist will submit your claim to MetLife for you so there are no claim forms to fill out. Additionally, you are not required to pay an annual deductible for in-network treatment.

When you receive services from a MetLife participating dentist, benefit payments are based on the dentist's negotiated fees. When making an appointment, tell the dentist's office that you are a MetLife dental plan participant. By making the dentist's office aware that you are a network plan participant, you will receive the negotiated rates and avoid later billing adjustments from an in-network provider.

If you use a provider who practices at more than one location, the provider may not participate in the network in all of their locations. Prior to obtaining any dental service, you should verify the provider's network participation at the location you visit by contacting MetLife. Also, if a member of a dental practice is a participating MetLife network dentist, it is possible that other dentists in that practice are not.

Since participating providers can join and leave the network at any time, it's a good idea to confirm that your dentist is currently a network provider prior to receiving treatment. You can obtain a list of current network participating providers through www.metlife.com/mybenefits or by calling MetLife.

Geographic Areas

The negotiated fees charged by participating dentists reflect differences in negotiated dental charges by geographic area. Each participating MetLife network dentist agrees to accept a geographically-based negotiated rate as payment in full. That fee determines what the dentist will charge for services to eligible IBM employees. These geographically-based negotiated rates are not published to employees, but you may contact MetLife for reimbursement rates for specific procedures.

PAYING FOR DENTAL SERVICES

At the time you receive dental services, your dentist may require you to pay the amount of your copayment or the full negotiated fee. Your copayment is the difference between the amount of the dentist's charges, up to the U&P rate if you visit an out-of-network provider, and the percentage paid by MetLife for that type of service.

Out-of-Network Providers

You may visit any appropriately-licensed dentist of your choice. However, if that dentist is not a participating MetLife network dentist, reimbursement will be based on a percentage of the U&P rate. If

you receive treatment from an out-of-network dentist, you may be responsible for filing your own claims. See "How to File a Claim" in the Administrative Information section for more information.

Pretreatment Estimate of Benefits

If your dentist recommends substantial treatment (in excess of $200), you should request a pretreatment estimate of benefits from MetLife by having your dentist submit a claim form with an explanation of the treatment plan and relevant clinical information, e.g., x-rays or narrative. MetLife will estimate your eligible benefits in advance, and may also suggest an alternative treatment method (see next page). A MetLife pretreatment estimate is valid for one year from the date issued. Estimates and authorizations must be in writing from MetLife and will not be given over the phone by Customer Service Representatives. Estimates will assume no other coverage and will not include information about prior services that may impact benefits reimbursements because of frequency limits or plan limitations.

Please note that a pretreatment estimate is not a claim determination or a guarantee of payment, which cannot be made until after a claim is submitted and processed. For example, actual payment for dental work you receive may be less than the pretreatment estimate, because of Plan limitations (such as frequency limits and annual and lifetime maximums) in effect when services are performed. Pretreatment estimates assume you do not have any other dental coverage — actual payments will be less if there is other dental coverage that is primary. No benefits are payable for services performed after termination of coverage.

If you do not obtain a pretreatment estimate, or choose a treatment not authorized for benefits by MetLife, you will be responsible for any difference in cost between the suggested alternative treatment, if any, and the treatment you receive.

PRETREATMENT ESTIMATE FOR IMPLANTS AND RELATED SERVICES

A pretreatment estimate is recommended for implants and other related services prior to work being done, in order to be eligible for any benefits. You and your dentist will each receive written notification of the benefits available for these services under the IBM Dental Plan.

Alternative Benefits

MetLife reserves the right to suggest an alternative treatment method if their review determines that there is more than one appropriate method to treat the patient's condition than the one being recommended or performed by the dentist. If an alternative method is identified, benefits will be based on the least costly generally-acceptable procedure for a specific treatment (i.e., restoring tooth to original function without incurring additional expense).

Examples of alternative benefits include, but are not limited to, the following services. Other services may also be subject to this provision:

Dental Service	Alternative Treatment
Fillings: Inlays, Onlays and Crowns	If a tooth can be repaired by a less costly method than an inlay, onlay or crown, the dental benefits will be based on the least costly generally-accepted method of repair. Replacement of existing crowns, inlays and onlays – once every seven years. When fillings with contiguous surfaces (surfaces that touch) are rendered on the same day, the contiguous surface(s) will only receive one benefit per tooth.
Crowns, Pontics and Abutments	Veneer materials may be used for front teeth or bicuspids; however, the dental benefits for molars will be based on a full cast restoration.

Dental Service	Alternative Treatment
Bridgework and Dentures	Dental benefits will be based on the least-costly method of treating the entire dental arch which still provides a functioning level. In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the dental benefits will be based on the cost of a replacement denture unless adequate results can be achieved only with fixed bridgework.
Implants and Related Services	Due to the fact that implants and related services are costly, a pretreatment estimate is recommended prior to work being done in order to be eligible for any benefits. The first phase of this type of work is generally not subject to the alternative benefit provisions; benefits will either be approved or denied. The second phase of treatment generally is subject to the alternative benefit provision. An alternative benefit for the final restoration over the implant will be determined and may be reimbursed upon final completion of the work.

Emergency Care Under the IBM Dental Plan

If emergency dental treatment is required, contact your dentist. Charges will be considered for reimbursement in accordance with the percentage rates previously described if eligible under your dental option.

WHAT'S COVERED UNDER THE IBM DENTAL PLAN

Generally, dental services (including most oral surgery) are eligible for benefits to the extent that they are necessary and appropriate for dental health and are considered eligible procedures under the IBM Dental Basic and IBM Dental Plus options. The most common procedures for each dental service type are included in the summary that follows. To verify coverage and for specific information on any procedure, especially those not noted below, you should contact a MetLife customer service representative, as there are replacement and frequency limitations that may apply.

All eligible services will be reimbursed by the Plan you are enrolled in and your employment status (active or retired) at the time the service is completed. These payments apply to eligible services wherever they are performed, such as the dentist's office or the hospital. Please check with your health plan regarding precertification of your hospital stay.

The annual maximum carries over to/from Dental Plus and Dental Basic when plan changes occur during the same calendar year. If you reach your annual maximum under IBM Dental Plus or IBM Dental Basic, no further dental benefits claims will be payable for that year. The annual maximum restarts on January 1st of the following year for services incurred during that same year.

Preventive Treatment

- *Cleanings,* two per calendar year.
- *Oral examinations, including but not limited to routine or problem focused examinations,* two per calendar year.
- *X-rays,* one complete full-mouth x-ray series or panoramic x-ray per 60 months.
- *Topical fluoride treatments,* once per calendar year.
- *Sealants,* one per tooth per lifetime.

Basic Restorative Treatment

- Amalgam and composite fillings.

Major Restorative Treatment (Dental Plus only)

- General ***anesthesia,*** treatment will be reviewed by MetLife for dental necessity. Coverage may be combined with the benefit for other services rendered on the same day.
- Caps, crowns, implants, inlays and onlays.
- ***Replacement of existing crowns,*** inlays or onlays, once every seven years.
- ***Endodontic treatment,*** including root canals.
- ***Extractions,*** including anesthesia and routine postoperative care.
- ***Implants.*** A pretreatment estimate is recommended for implants and other related services prior to work being done, in order to be eligible for any benefits. You and your dentist will each receive written notification of the benefits available for these services under the IBM Dental Plan.

BENEFIT DETERMINATION GUIDELINES FOR GENERAL ANESTHESIA/IV SEDATION

Benefits may be available, as determined by the dental plan, for general anesthesia/IV sedation when it is performed in conjunction with the following dental procedures:

- The surgical extraction of two or more teeth completed on the same date.
- When three or more standard extractions of teeth are completed on the same date.
- The closure of an oral antral fistula.
- The surgical exposure of an impacted tooth that is to be retained for orthodontic purposes if orthodontics is covered by the Plan.
- When two or more implants are placed and the implants have been approved for benefits.
- When a standard tooth extraction and a surgical tooth extraction are completed on the same date.

There may be occasions where benefits for general anesthesia/IV sedation are available when a patient has unique needs or where there are clinical situations that warrant its use because local anesthesia administration would not suffice. Some examples include:

- Mentally or physically disabled covered individuals.
- Age of patient - up to seven years - unmanageable
- Patient with spastic disease.
- Infection at injection site where local anesthetic would normally be administered.
- Allergy to local anesthesia.
- Failure of local anesthesia to control pain.
- Extent of surgery - complicated surgical procedures that occur in multiple quadrants of the oral cavity on the same date.

- *Periodontal treatment:*
  - Scaling and root planing are limited to one per quadrant per 24 months. The clinical parameters used for rendering a benefit determination, based on submitted documentation, are as follows: pathologic periodontal pocket depth of 4 mm or greater and evidence of the loss of periodontal ligament attachment (bone loss).
  - Osseous surgery up to four quadrants within a 36-month period.
  - Periodontal procedures (periodontal maintenance) are limited to four per calendar year (this includes adult and child prophylaxis) and are only payable when there is a history of qualifying periodontal therapy, in at least two different quadrants.
  - Local chemotherapy agents used in conjunction with non-surgical periodontal therapy (scaling and root planing). are limited to one per tooth, and for a limited number of teeth that have pocket depth between 6 mm and 8 mm and bleed probing, and have had no chemotherapeutic agent applied for at least the prior 12-month period, as determined by the Plan's Dentist Consultants.

  - Local chemotherapy agents used in conjunction with periodontal maintenance therapy (post scaling and root planing or osseous surgery) are limited to one per tooth for a limited number of teeth that show increasing pocket depths between 5 mm and 8 mm and have had no chemotherapeutic agent applied for at least the prior 12-month period. Benefits may be available based on review of the clinical documentation by the Plan's Dentist Consultants, when there is a history of completed active periodontal therapy.
- ***Creation of bridgework and dentures***, including six months post-placement care, once every seven years.
- ***Relining existing bridgework or dentures***, no coverage is available during the first six months following the date of the insertion of the prosthesis; thereafter, no limit.
- ***Replacement of existing dentures or bridgework.*** For treatment to be eligible the following conditions must be met
  - The existing denture or bridgework was installed at least seven years prior to its replacement or
  - The replacement is required to replace one or more natural teeth extracted after placement of the original denture/bridge and the appliance cannot be made serviceable or
  - The existing denture or bridgework is temporary and cannot be made permanent, and replacement by a permanent denture/bridge occurs within 12 months from the date of initial installation of the temporary denture/bridge.

Note: Any dental treatment for dentures or bridgework received under the IBM Dental Plan will be treated as if it was received under the IBM Dental Plus Plan. For example, if a covered individual received dentures or bridgework less than seven years ago under the IBM Dental Plan and that individual is now covered under the IBM Dental Plus option, new dentures or bridgework may not be replaced until seven years have passed. Temporary dentures are not a covered expense.

- ***Temporomandibular joint dysfunction*** (TMJ)-related charges:
  - X-rays, up to six views, (considered a diagnostic procedure)
  - TMJ appliance
  - TMJ office visits/treatments, up to 10 per year, including eligible services of other providers for associated treatment and MRIs are only covered if determined to be dentally necessary.

You are strongly urged to contact MetLife to be aware of what the IBM Dental Plus option will cover before you or your eligible dependent receive services in conjunction with TMJ. TMJ-related surgical charges not covered under the IBM Dental Plus option may be eligible for IBM Medical Plan benefits in certain rare circumstances. See "What's Covered Under the IBM Medical Plan."

Major Restorative Benefits If You Retire

If you retire while covered under the IBM Dental Plus option, you and each covered individual will be eligible for 50% reimbursement for major restorative services. If you are retiring and have work in progress, your services will be reimbursed based on the plan you are enrolled in and your employment status (active or retired) at the time the service is completed. You may want to check with MetLife regarding your individual circumstances.

ORTHODONTIC TREATMENT (IBM DENTAL PLUS)

Orthodontic treatment is covered under the IBM Dental Plus option for each eligible covered individual up to a lifetime maximum of $2,500. The administration of the orthodontic benefit differs from that of other dental services. Here's how:

- When submitting a claim for comprehensive orthodontic treatment, it is only necessary to submit the claim once, at the beginning of the active treatment period. However, additional information may be requested periodically to verify that you or your dependent is still receiving active treatment. Payment will be made to you or the dentist, as indicated on the claim form.
- After the active treatment phase has commenced — placement of the bands upon the teeth — 25% of the total orthodontic charge will be considered the banding fee. Benefits will be paid at 50% of the banding fee and will be made upon submission of the claim form.
- After subtracting the banding fee, the remaining charge for eligible services while the bands are on the teeth will be divided by the number of months of treatment that the orthodontist indicates is required. (Charges include necessary appliances, diagnostic casts, x-rays and subsequent monthly visits while the bands are on the teeth.)
- You will receive a monthly reimbursement check equal to 50% of this calculated monthly amount. Payment for active treatment will end when bands are removed, the patient reaches the lifetime orthodontia maximum or if no longer covered by the IBM Dental Plus option, whichever occurs first, and no further reimbursement will be made.
- Reimbursement will be paid in monthly installments over the course of the treatment, thus the full reimbursement will not be received until conclusion of the active treatment has been reached. Monthly benefits will be sent automatically to you or to your dentist, per your designation on the claim form.
- MetLife will confirm treatment periodically.

Automatic payment will cease if you or your covered family member are no longer covered by the IBM Dental Plus option.

Orthodontic Benefits If You Retire

If you are retiring and have work in progress, your services will be reimbursed based on the plan you are enrolled in and your employment status (active or retired) at the time the service is completed. You may want to check with MetLife regarding your individual circumstances.

WHAT THE IBM DENTAL PLAN DOES NOT COVER

- Treatment for accidental injury to sound natural teeth is not covered by MetLife. However, if you are enrolled in the IBM PPO, IBM PPO Plus, IBM EPO or the IBM PPO with HSA, IBM Enhanced PPO with HSA options, you may be eligible for medical benefits if the health plan determines that accidental injury coverage applies.
- Charges for cosmetic dental services.
- Charges for educational programs (such as training in plaque control, nutritional guidance or myofunctional therapy).
- Experimental, investigational or unproven treatment or procedures.
- Incidental dental procedures. An incidental dental procedure is one that is performed at the same time as a more complex primary procedure and requires little additional dental resources, and in the dental industry, generally identified to be part of the primary procedure code.
- When multiple procedures are done on the same tooth on the same day, MetLife will reimburse only for the most complex procedure done for that date of service.
- Nitrous oxide.

- Prescription drugs are not covered under the Dental Plan; however, eligible medications prescribed by your dentist may be covered under your IBM Medical Plan option (IBM PPO, IBM PPO Plus, IBM EPO, IBM PPO with HSA or the IBM Enhanced PPO with HSA). If you are enrolled in an HMO, contact your HMO to determine how prescriptions for dental treatment are covered.
- Protective athletic mouth guards.
- The cost of replacing lost or stolen prosthetic devices, including space maintainers.
- Retainers are not covered as a separate benefit, but are included under orthodontia services.
- Reimbursement of courses of treatment for patients whose treatment was completed before their coverage began is not covered.
- Charges for oral surgery that are determined to be dental in nature, and exceed the U&P rate, are not eligible for reimbursement under the IBM Medical Plan options.
- Temporary dentures.
- Services not performed or prescribed by a licensed dentist.

COORDINATION OF BENEFITS

If you or an eligible family member has other group health plan coverage in addition to IBM coverage, IBM medical and dental benefits will be coordinated with the other coverage to avoid duplication of payment. When the IBM Plan's responsibility for benefits is secondary to that of the other coverage, the IBM Plan will not pay a benefit for an eligible expense until the other coverage has paid, and the IBM Plan will take the covered expense and subtract what the primary carrier paid, then issue benefits based on the plan percentage. amount which would normally apply will be reduced by the amount the other coverage paid.

See "Coordinating Coverage" in the Administrative Information section for more information.

WHEN COVERAGE ENDS

When a person ceases to be eligible for dental coverage through IBM, continuation coverage can be obtained, in certain circumstances, through the Transitional Medical Program (TMP) for a limited time. See "Transitional Medical Program (TMP)" in the Administrative Information section for more details.

IBM Vision Coverage

IBM Vision Coverage

ABOUT YOUR VISION BENEFITS

If you are eligible, you have two options for vision coverage in which you can enroll: the IBM Vision Plan offered by Anthem Blue View Vision or the EyeMed Vision Discount Plan, provided by EyeMed Vision Care.

IBM VISION PLAN ADMINISTRATOR

Anthem Blue View Vision is the administrator of the IBM Vision Plan.

You can reach Anthem Blue View Vision at 855-765-4552

EYEMED VISION DISCOUNT PLAN

You can reach EyeMed Vision Care at 855-245-0621.

Who Is Eligible

All regular full-time, regular part-time and long-term supplemental employees and their eligible family members are eligible for the IBM Vision Plan or EyeMed Vision Discount Plan. Employees enrolled in the IBM Global Assignee Medical Plan will receive their vision coverage through Cigna Global Health Benefits.

IBM's dependent eligibility guidelines pertain to all benefit options under the IBM Personal Benefits program, including vision policy, and are not subject to any state laws mandating coverage for anyone not included in IBM's list of eligible dependents.

ID Card

If you enroll in the IBM Vision Plan, you will receive an ID card, which will remain good for as long as you are enrolled in this plan. New cards will not be sent each year.

IBM VISION PLAN

The IBM Vision Plan is designed to encourage you to maintain your vision through regular eye examinations and to help you with vision care expenses for required glasses or contact lenses. The routine eye exams covered through the IBM Vision Plan are designed to maintain your visual heath as well as detect heath conditions that could impact your overall health. The routine eye exams through the IBM Vision Plan are not designed to cover the treatment or monitoring of existing health conditions.

Benefits for the IBM Vision Plan are provided by Anthem BlueView Vision through a fully-insured vision policy, which offers coverage for services from both network providers and vision providers who are not in the network.

Enrollment in the IBM Vision Plan provides benefits for eye exams and eyewear both within and outside the Anthem Blue View Vision network.

EyeMed Vision Discount Plan

The EyeMed Vision Discount Plan, provided by EyeMed Vision Care™ is available to you and your eligible dependents at no cost. This plan gives you access to savings of up to 40% on frames, lenses, lens options and contact lenses, and a discount on an annual eye exam at EyeMed Vision Care network

provider locations. No enrollment or ID card is required to access the discounts, you just need to go to a participating provider and ask for the EyeMed Discount.

For more information, visit www.eyemed.com. Click on Member Login, scroll down to Discount Plan Members and choose letter "I" for the IBM Discounts, then click on the IBM Vision Discounts link.

When Coverage Ends

If you, or an enrolled family member, cease to be eligible for vision coverage through IBM, continuation coverage can be obtained, in certain circumstances, through the Transitional Medical Program (TMP) for a limited time. See "Transitional Medical Program (TMP)" in the Administrative Information section for more details.

IBM Flexible Spending Accounts

IBM Flexible Spending Accounts

Flexible spending accounts provide an easy way to set aside money for certain eligible expenses while reducing your taxable income. There are two Flexible Spending Accounts described in this section:

- The Health Care Spending Account (HCSA).
- The Dependent Care Spending Account (DCSA).

Eligible employees may elect to participate in the Health Care Spending Account, the Dependent Care Spending Account, neither or both accounts.

WHO IS ELIGIBLE FOR FLEXIBLE SPENDING ACCOUNTS

You are eligible to elect coverage under the Flexible Spending Accounts if, at the time of enrollment, you are an active regular full-time employee, regular part-time employee or long-term supplemental employee who is eligible to participate in the IBM Personal Benefits Program, paid from the IBM payroll, and subject to U.S. tax laws. (Supplemental employees and retiree supplemental employees are not eligible to participate.)

An employee who is on a leave of absence and working as a supplemental employee will become eligible to elect coverage only when he or she returns to regular full-time or regular part-time status.

FLEXIBLE SPENDING ACCOUNTS ADMINISTRATOR

The administrator for the HCSA and for the DCSA is Acclaris.

Customer Service Availability
Acclaris representatives are available to assist you with claim questions Monday through Friday from 8:00 a.m. to 8:00 p.m., Eastern time.

You can reach an Acclaris representative at 888-880-2775 or online at www.acclarisonline.com.

Health Care Spending Account

Employees who are enrolled in the IBM PPO with HSA, IBM Enhanced PPO with HSA are not eligible to participate in the Health Care Spending Account.

Dependent Care Spending Account

You can participate in the DCSA only if dependent care is necessary for you and your spouse to work or for you to work and your spouse to attend school full-time.

ABOUT THE HEALTH CARE SPENDING ACCOUNT (HCSA)

The HCSA allows you to contribute a fixed amount of money (minimum of $10/month up to $2,650 per year) from your pay in pretax dollars and claim reimbursements from the account for eligible out-of-pocket health care expenses. These expenses, which you might otherwise have to pay with after-tax dollars, include deductibles, copayments and other medical, dental, vision and hearing expenses that are not reimbursed under your health plan or other coverage.

You can also claim reimbursements for expenses incurred by your spouse and eligible dependents, even if they are not enrolled under your benefits coverage. An eligible dependent is anyone you can properly claim as a dependent on your federal tax return. (If you and your spouse file separate tax returns, you cannot claim expenses for your spouse under your HCSA.) Due to IRS regulations, the Health Care

Spending Account cannot reimburse expenses for a domestic partner who does not meet the applicable tax law definition of "dependent."

The HCSA is "front-loaded". Employees are eligible for the total annual election on the first day of participation. However, reimbursements can be claimed only for eligible expenses you incur while covered under the HCSA. If your total contributions exceed your total reimbursements for eligible expenses incurred during a coverage period or any grace period that may apply immediately following the coverage period, you must forfeit the remaining amount, as required by federal law.

HOW THE HEALTH CARE SPENDING ACCOUNT WORKS

Contributions

When you enroll in the HCSA, you may elect to contribute up to an annual maximum, currently $2,650 (minimum election of $10 per month). The amount you are permitted to contribute is determined by the IRS. Contributions to your HCSA are deducted from your pay on a pretax basis each pay period before federal income, Social Security and, in most cases, state and local income taxes are calculated and withheld. Consult your personal tax advisor for information specific to your jurisdiction.

When you elect to participate in the HCSA, you agree to participate for the entire plan year. You may not change your contribution during the year, except if you experience a qualified status change that allows you to make a mid-year change (see "Changing Coverage Due to a Qualified Status Change" in the "Administrative Information" section).

If your spouse is also enrolled in a health care spending account through his or her employer, each of you may contribute up to the maximum amount allowed by your respective plans; however, you may claim reimbursement for an eligible expense from one or the other of the plans only. Duplicate reimbursement for the same expense is not allowed.

IMPORTANT INFORMATION FOR IBM COUPLES

If you and/or your spouse are participating in the HCSA and one of you terminates participation in the HCSA due to a qualified status change, there will be no carryover of unused HCSA contributions from the terminating participant's account to the other spouse's account.

For example, let's say you participate in the HCSA at a contribution rate of $50 per month ($600 for the year) and you take a leave of absence on June 25th, causing you to terminate participation in the HCSA. Your HCSA coverage period ends June 30th (the last day of the pay period in which you terminate). Only expenses incurred on or before June 30th will be eligible for reimbursement under your HCSA account.

If your spouse enrolls in the HCSA effective July 1st and contributes $50 per month (your spouse may enroll in HCSA within 30 days following your qualified status change), only expenses incurred on or after July 1st will be eligible for reimbursement under the new HCSA account.

Your Coverage Period and Election Changes

Your "coverage period" is a continuous period, within the plan year, throughout which your rate of contribution remains constant. Normally, your coverage period ends on December 31st. If your monthly contribution to the HCSA stays the same throughout the plan year, you will have a single 12-month coverage period. For eligible expenses incurred during a coverage period, you may receive reimbursements up to the "coverage period amount." This amount is calculated by multiplying your rate of contribution times the number of pay periods in the plan year from the start of the coverage period.

If you elect the HCSA during the annual enrollment period, your coverage starts on January 1st of the following plan year.

WHEN CONTRIBUTIONS ARE DEDUCTED FROM YOUR SALARY

Due to payroll cycles there may be a delay in your salary adjustment.

Treatment for new hires is explained in "Enrolling in Your Benefits as a New Hire" in the Personal Benefits Program section.

If you enroll in the HCSA or change your deduction during the plan year as the result of a qualified status change (see "Changing Coverage Due to a Qualified Status Change" in the Administrative Information section), your coverage period and deductions are effective on the first day of the month following the date of your phone call to the IBM Benefits Center – Provided by Fidelity.

Your prior coverage period and coverage period amount will end the preceding day. Each continuous period for which your monthly contribution amount is the same will be considered a separate "coverage period." Coverage periods are treated separately, so expenses are applied against the particular coverage period in effect at the time the expense was incurred. For example, if you have a baby, you can increase your HCSA amount. However, it's very important to know that since the increase in your HCSA is effective the first of the month following your call to the IBM Benefits Center after the baby's birth, expenses incurred for the birth of the baby will not be eligible under your new coverage period.

REDUCING HCSA CONTRIBUTIONS TO ZERO

If you stop contributing to the HCSA prior to December 31st of the plan year due to a qualified status change, you cannot be reimbursed for expenses incurred after changing your contributions nor qualify for a grace period. In that case, you may claim reimbursement only for eligible expenses incurred during the portion of the plan year for which you actually made contributions to the HCSA.

For any grace period, expenses are applied against the coverage period amount for the particular coverage period in effect immediately before the start of the grace period.

EXAMPLE: CHANGING YOUR HCSA CONTRIBUTION DURING THE YEAR

Let's say you elect to contribute $20 a month ($240 a year) to the HCSA. You contribute $20 per month from January through March for a total of $60 contributed to date. During this time period, you also incurred $200 in eligible health care expenses, for which you've already received reimbursement.

In March, you have a baby and elect to increase your HCSA contribution to $100 per month. To calculate your new eligible HCSA balance for the remainder of the plan year, you add together the actual contributions made during the first coverage period (January through March) to the new contributions for the second coverage period (April through December). This new amount will be reduced by the amount you've already received in reimbursements ($200) for a new total available balance of $760, as shown in the table below. *Note:* Since the change is effective the first of the month following your call to the IBM Benefits Center, expenses incurred for the birth of the baby will not be eligible under your new coverage period. Expenses incurred during the first coverage period can only be reimbursed against the first coverage period amount. Expenses incurred during the second coverage period can only be reimbursed against the second coverage period amount.

Example of Calculating a New HCSA Balance When There Are Two Coverage Periods	
Contribution Amount for 1st Coverage Period (January – March)	$20 x 3 months = $60
Contribution Amount for 2nd Coverage Period (April – December)	$100 x 9 months = $900
New HCSA Annual Amount (1st Coverage Period plus 2nd Coverage Period)	$60 + $900 = $960
Less any reimbursements received during 1st Coverage Period	$960 - $200
Equals New HCSA available balance during the 2nd Coverage Period:	$760

Keep in mind that if your reimbursement for expenses incurred during the coverage periods during the plan year does not reach the amount you have contributed during the plan year, the remaining amount will be forfeited. You will not receive a refund, nor will you carry over any unused portion of your coverage to another plan year, unless a grace period applies immediately following the second coverage period. See "Health Care Spending Account Grace Period."

REIMBURSEMENTS

After you incur an eligible health care expense that is not reimbursable by your health care plans or any other coverage, you may submit a claim to Acclaris for reimbursement from your account. You will be reimbursed for the lesser of the amount of the eligible expense or the coverage period balance amount.

You may receive reimbursements only for expenses incurred during the coverage period or *any* grace period that may apply immediately following the coverage period. An expense for a service or item is considered "incurred" on the date the service is rendered, regardless of date of billing, date of payment or date the item is provided.

You may not receive reimbursement for expenses incurred during a period in which you were not contributing to the Plan. However, you may receive reimbursement for expenses incurred during a grace period that applies immediately following a coverage period, even if you are not contributing to the Plan during that grace period as outlined in the "Health Care Spending Account Grace Period" section.

Eligible Expenses Incurred by Your Spouse and Eligible Dependents

You may receive reimbursement from your account for eligible health care expenses incurred by your spouse and eligible dependents, even if they are not enrolled in other IBM benefits coverage. An eligible dependent is anyone you claim as a dependent on your federal tax return, including:

- Your spouse, only if you jointly file your Federal Income Tax Return.
- Children or relatives in your household for whom you provide over 50% of support during the calendar year in which you make contributions to the account.
- Due to IRS regulations, HCSA cannot reimburse expenses for domestic partners, except those who meet the applicable tax law definition of "dependent."

Health Debit Card for Health Care Spending Account

For Health Care Spending Account participants, a Health Debit Card will be provided. The Health Debit Card program is administered by Acclaris. The Health Debit Card enables you to pay for qualified medical, dental or vision expenses at the doctor's office, hospital or lab in addition to prescription drugs at the pharmacy.

When you use the Health Care Debit Card, your Health Care Spending Account will be debited for qualified expenses that are eligible for reimbursement under the Health Care Spending Account. This eliminates the need to file claims to receive reimbursement for these eligible expenses.

The IBM Health Debit Card can be used at both IIAS (IIAS is a certification system used by Merchants to identify eligible healthcare products) and 90% retailers (a retailer where at least 90% of the products sold are eligible health care spending account expenses as defined by the IRS). This means that the transaction will be approved for payment at the point of sale regardless of whether the retailer is IIAS or 90%. Swipes at an IIAS retailer are substantiated at the point of sale and do not require receipts. Swipes at 90% retailers cannot be substantiated at the point of sale. Since the IRS requires ALL expenses to be substantiated, you must provide a receipt for any debit card purchases at a 90% retailer. For a listing of 90% and IIAS merchants, please visit https://www.sig-is.org.

Continuing Your Participation if You Leave the Company

If you leave the Company during the year (or otherwise cease to meet the HCSA participation criteria), you may be eligible to continue your coverage for the rest of the year by making contributions on an after-tax basis. You could then receive reimbursements for expenses incurred after the status change and perhaps avoid forfeiture of unused contributions. Contact the IBM Benefits Center – Provided by Fidelity for further information.

FORFEITURE OF UNUSED CONTRIBUTIONS

By law, the Health Care Spending Account carries a "use it or lose it" provision. If your total contributions for any particular coverage period exceed your total reimbursements for eligible expenses incurred during that coverage period, you will forfeit the difference. You cannot receive a refund. IBM will use any forfeited amounts to offset expenses of administering the Health Care Spending Account for its employees.

ELIGIBLE EXPENSES UNDER THE HEALTH CARE SPENDING ACCOUNT

Generally, expenses for health care services and supplies are eligible for reimbursement if they are for medical care; considered tax-deductible by the IRS; not reimbursable by a benefits plan, an HMO, insurance or any other source; and incurred by you, your spouse or eligible dependents during your coverage period.

Examples of eligible services and supplies recognized by the IRS, at the time of publication of this document, include:

- Acupuncture
- Alcoholism treatment
- Ambulance services
- Annual deductible
- Artificial limbs
- Birth prevention surgery
- Braille books and magazines for a visually-impaired or blind person
- Car equipped for a disabled person
- Chiropractic services
- Cholesterol kits
- Christian Science practitioner
- Contact lenses, saline solution and enzyme cleaner

- Copayments
- Crutches
- Custodial care in an institution or nursing home
- Deductibles under medical, dental and vision plans
- Doctors' fees
- Drug addiction treatment
- Eyeglasses (including prescription sunglasses)
- Service animal
- Hearing aids and hearing care
- Hospital services
- Insulin
- Laboratory fees
- Legal sterilization procedures
- Lodging for medical care away from home (up to $50/day per person, up to two people)
- Nicotine gum, patches and other smoking cessation aides
- Nursing services
- Organ transplants
- Orthodontic treatment
- Oxygen and oxygen equipment
- Photo-refractive surgery
- Physical exams
- Prescription drugs (if not taken for cosmetic purposes, e.g., hair growth)
- Prescription drugs to alleviate nicotine withdrawal
- Psychiatric treatment
- Psychologists' fees
- Radial keratotomy/PRK/LASIK
- Smoking cessation program
- Social workers' fees
- Special equipment for the deaf or hard of hearing
- Special homes or schools for the mentally or physically disabled
- Transportation, primary for and essential to, medical care
- Wheelchairs
- Weight-loss programs (requires a doctor's statement confirming physician-diagnosed obesity, diabetes or hypertension). The cost of reduced-calorie food and weight-loss programs for improvement of general health are not eligible and
- X-ray fees.

IRS PUBLICATION 502: MEDICAL AND DENTAL EXPENSES

For more information about eligible health care expenses, consult your personal tax advisor or read IRS Publication 502, Medical and Dental Expenses, available at www.irs.gov.

Please note that Publication 502 is intended for use on individual Federal Income Tax Returns and in some cases details in Publication 502 may not apply to flexible spending accounts such as the HCSA. If there is a conflict between any item in the HCSA section of this document and Publication 502, this section will govern.

Over-the-Counter Drugs and Medications

Under the Patient Protection and Affordable Care Act, over-the-counter medications are no longer eligible for reimbursement under health care flexible spending accounts (FSAs) and health savings accounts (HSAs) unless prescribed by a physician or other medical provider.

INELIGIBLE EXPENSES UNDER THE HEALTH CARE SPENDING ACCOUNT

Examples of services and supplies that are not eligible for reimbursement, as defined by the IRS, include but are not limited to:

- Any expense for the betterment of general health
- Any portion of an expense that has been reimbursed (or is reimbursable) by a company's health care plan, HMO, insurance or any other source
- Condoms
- Cosmetic medical or dental services and care (including prescription drugs)
- Cosmetics, toiletries and related items
- Dancing or swimming lessons
- Dietary supplements
- Family or marriage counseling
- Funeral and burial expenses
- Health club dues
- Herbal and homeopathic remedies/medicines
- Long-term care insurance premiums
- Maternity clothes
- Meals and lodging expenses while receiving medical care away from home
- Nutritional supplements
- Over-the-counter drugs and medications without a prescription
- Pregnancy tests
- Premiums for health insurance or other health care coverage (for example, your monthly contributions for IBM medical or HMO or an insurance policy purchased on your own)
- Toiletries, such as toothpaste and vitamins
- Vitamins and nutritional supplements available over-the-counter and
- Weight-loss programs for general health purposes.

HOW TO FILE A HEALTH CARE SPENDING ACCOUNT CLAIM

For specific claim instructions including claim submission deadlines, see "How to File a Claim" in the Administrative Information section.

Health Care Spending Account Grace Period

IBM provides a grace period for Health Care Spending Account participants. The grace period allows employees actively participating in HCSA on December 31to submit claims for eligible expenses incurred through March 15 of the following year — instead of the previous plan year end date of December 31. These eligible expenses can be reimbursed using your HCSA contributions that remain unused (if any) from your coverage period in effect as of December 31. You are not required to participate in the Health Care Spending Account for the current plan year in order to take advantage of the grace period for the previous plan year. (In other words, if you participate in the HCSA in 2019, you may submit claims through March 15, 2020.)

If you are participating in the Health Care Spending Account, you must indicate on the Health Care Spending Account Claim Form if the expenses incurred during the grace period should be reimbursed from your previous year's contributions or your current year contributions. Otherwise, your current year contributions (if applicable) will be used to reimburse any eligible expenses incurred from January 1 of the previous plan year through March 15 of the current plan year.

If your medical plan option participates with the Health Debit Card, please note that only current plan year contributions can be applied to any eligible prescription drugs you purchase with the card. If you wish to use your previous plan contributions to pay for prescription drugs purchased during the grace period, you will need to pay for them using another form of payment. You must then submit a claim for reimbursement, checking the box on the claim form indicating the expense should be reimbursed from your previous year's contributions, instead of using your Health Debit Card.

IBM PPO with HSA, IBM Enhanced PPO with HSA Participants

If you enroll in the IBM PPO with HSA, IBM Enhanced PPO with HSA as your medical option, were a participant in the Health Care Spending Account on December 31 of the previous year and had a zero balance remaining in your HCSA, you are eligible to make contributions to your HSA beginning January 1. If you had a balance remaining in your HCSA, you cannot begin making contributions until April 1of the year after you enroll as the IRS considers your HCSA balance "other coverage." IRS rules prevent you from participating in HSA while you have other coverage. You may, however, contribute up to the full year HSA contribution limits between April 1 and December 31.

HEALTH CARE SPENDING ACCOUNT TESTING

In order to meet federal requirements for favorable tax treatment, the Health Care Spending Account must maintain certain relationships of eligibility, participation and utilization between highly and non-highly compensated employees. In the event it should become necessary, IBM may take actions to maintain the tax-favored status, such as limiting the contributions of highly-compensated employees. If the account does not meet IRS guidelines, certain employees may not be able to contribute the full annual amount they elected on a tax-free basis. You will be contacted if this affects you.

The Plan may be modified or discontinued in the future at IBM's discretion. Circumstances which may lead to such action include possible tax law changes or legislative regulatory requirements.

ABOUT THE DEPENDENT CARE SPENDING ACCOUNT (DCSA)

The Dependent Care Spending Account (DCSA) allows you to contribute a fixed amount of money (minimum of $20 per month, up to $5,000 per year) from your pay in pretax dollars to help pay for work-related dependent care expenses. These expenses, which you might otherwise have to pay with after-tax dollars, include before- and after-school care programs for school-age children under age 13, day care center services and home care services for a dependent who is incapable of self-care and day camp expenses. Please note that Dependent Care Spending Account benefits described in this section are not subject to ERISA, the federal law governing employee benefits.

For purposes of the Dependent Care Spending Account, eligible dependents generally include:

- Children under age 13 whom you are entitled to claim as exemptions on your federal income tax return and
- Any dependent age 13 or older whom you are entitled to claim for federal income tax purposes, who is in your household at least eight hours a day, and who is physically or mentally incapable of self-care.

Reimbursements can be claimed only for eligible expenses you incur while covered under the DCSA. If your total contributions exceed your total reimbursements for eligible expenses incurred during a coverage period or any grace period that may apply immediately following the coverage period, you must forfeit the remaining amount, as required by federal law.

HOW THE DEPENDENT CARE SPENDING ACCOUNT WORKS

Contributions

When you enroll in the DCSA, you may elect to contribute up to an annual maximum, currently $5,000 (minimum election of $20 per month). However, if you are married and you and your spouse file separate federal income tax returns, each of you can contribute a maximum of $2,500 per year. In no case may your contribution exceed your earned income or that of your spouse, whichever is less.

If your spouse is a full-time student or was disabled for at least five months during the year, there is a special rule to determine his or her annual income. To figure the income in such a case, determine your spouse's actual taxable income, if any, earned each month that he or she is a full-time student or was disabled. Then, for each month, compare this amount to $200 if you are claiming expenses for one dependent, or $400 if you are claiming expenses for two or more dependents. The amount you use to determine your spouse's annual income is the greater of the actual taxable income or these assumed amounts of $200 or $400.

Contributions to your DCSA are deducted from your pay on a pretax basis each pay period before federal income, Social Security and, in most cases, state and local income taxes are calculated and withheld. Consult your personal tax advisor for information specific to your jurisdiction.

When you elect to participate in the DCSA, you agree to participate for the entire plan year. You may not change your contribution during the year, except if you experience a qualified status change that allows you to make a mid-year change (see "Changing Coverage Due to a Qualified Status Change" in the Administrative Information section).

If your spouse is also enrolled in a dependent care spending account through his or her employer, each of you may contribute up to the maximum amount allowed by your respective plan; however, you may claim reimbursement for an eligible expense from one or the other of the plans only. Duplicate reimbursement for the same expense is not allowed.

IMPORTANT INFORMATION FOR IBM COUPLES

If you and/or your spouse are participating in the DCSA and one of you terminates participation in the DCSA due to a qualified status change, there will be no carryover of unused DCSA contributions from the terminating participant's account to the other spouse's account.

For example, let's say you participate in the DCSA at a contribution rate of $50 per month ($600 for the year) and you take a leave of absence on June 25th, causing you to terminate participation in the DCSA. Your DCSA coverage period ends June 30th (the last day of the pay period in which you terminate). Only expenses incurred on or before June 30th will be eligible for reimbursement under your DCSA account.

If your spouse enrolls in the DCSA effective July 1st and contributes $50 per month (your spouse may enroll in DCSA within 30 days following your qualified status change), only expenses incurred on or after July 1st will be eligible for reimbursement under the new DCSA account.

Your Coverage Period and Election Changes

Your "coverage period" is a continuous period, within the plan year, throughout which your rate of contribution remains constant. Normally, your coverage period ends on December 31st. If your monthly contribution to the DCSA stays the same throughout the plan year, you will have a single 12-month coverage period. For eligible expenses incurred during a coverage period, you may receive reimbursements up to the "coverage period amount." This amount is calculated by multiplying your rate of contribution times the number of pay periods in the plan year from the start of the coverage period.

WHEN CONTRIBUTIONS ARE DEDUCTED FROM YOUR SALARY

Due to payroll cycles, there may be a delay in your salary adjustment.

Treatment for new hires is explained in "Enrolling in Your Benefits as a New Hire" in the Personal Benefits Program section.

If you elect the DCSA during the annual enrollment period, your coverage starts on January 1st of the following plan year.

If you enroll in the DCSA or change your deduction during the plan year as the result of a qualified status change (see "Changing Coverage Due to a Qualified Status Change" in the Administrative Information section), your coverage period and deductions are effective on the first day of the month following the date of your phone call to the IBM Benefits Center – Provided by Fidelity.

Your prior coverage period and coverage period amount will end the preceding day. Each continuous period for which your monthly contribution amount is the same will be considered a separate "coverage period." Coverage periods are treated separately, so expenses are applied against the particular coverage period in effect at the time the expense was incurred. For example, if you have a baby, you can increase your DCSA amount.

REIMBURSEMENTS

After you incur an eligible dependent care expense, you may submit a claim to Acclaris for reimbursement from your account. You will be reimbursed for the lesser of the amount of the eligible expense or the coverage period balance amount.

You may receive reimbursements only for expenses incurred during the coverage period. An expense for a service or item is considered "incurred" on the date the service is rendered, regardless of date of billing or date of payment.

You may not receive reimbursement for expenses incurred during a period in which you were not contributing to the Plan.

REDUCING DCSA CONTRIBUTIONS TO ZERO

If you stop contributing to the DCSA prior to December 31st of the plan year due to a qualified status change, you cannot be reimbursed for expenses incurred after changing your contributions nor qualify for a grace period. In that case, you may claim reimbursement only for eligible expenses incurred during the portion of the plan year for which you actually made contributions to the DCSA.

Eligible Dependents for Dependent Day Care Expenses

You may receive reimbursement from your account for eligible dependent care expenses incurred by the following members of your household:

- A child under age 13 whom you claim as a dependent for federal income tax purposes.
- A spouse or dependent, mentally or physically incapable of self-care (i.e., cannot dress, clean or feed himself or herself; or requires the constant attention of another individual to prevent injury to that person or others). *Note: If you are using the Dependent Care Spending Account for an adult dependent, the adult dependent must live with you at least half the year to be an eligible dependent.*

If you are unsure of a dependent's qualification, you should consult your personal tax or financial advisor.

Special rules apply to children of separated or divorced parents (consult your personal tax advisor for details).

Due to IRS regulations, the DCSA will not reimburse expenses for the care of domestic partners, except those who meet the applicable tax law definition of "dependent." By law we cannot treat an employee with a domestic partner as "married" for purposes of determining the employee's maximum allowable contribution to the DCSA.

Spend-Down Provision if You Leave the Company

If you leave the Company during the year you will no longer contribute to the DCSA. The amount contributed to DCSA while actively employed can be reimbursed for qualified dependent care expenses incurred after termination of employment through the end of the plan year, December 31st. To be eligible, expenses incurred must allow a participant or spouse to work. The reimbursement request form must include confirmation that you and your spouse are employed, looking for work, or attending school full-time

FORFEITURE OF UNUSED CONTRIBUTIONS

By law, the Dependent Care Spending Account carries a "use it or lose it" provision. If your total contributions for any particular coverage period exceed your total reimbursements for eligible expenses incurred during that coverage period, you will forfeit the difference. You cannot receive a refund. IBM will use any forfeited amounts to offset expenses of administering the Dependent Care Spending Account for its employees.

ELIGIBLE EXPENSES UNDER THE DEPENDENT CARE SPENDING ACCOUNT

Generally, expenses for dependent care are eligible for reimbursement if they are for work-related dependent care of an eligible dependent; considered deductible by the IRS and incurred during your coverage period. *If you are married, your spouse must also work unless he or she is a full-time student or incapable of self-care.*

Examples of eligible expenses recognized by the IRS at the time of publication of this document include:

- Before- and after-school care programs for school-age children under age 13.
- Day care center services (centers with more than six children must comply with all state and local regulations).
- Home care service for a dependent that is incapable of self-care.
- Day camp expenses.

IRS PUBLICATION 503: CHILD AND DEPENDENT CARE EXPENSES

For more information about eligible dependent care expenses, consult your personal tax advisor or read IRS Publication 503, Child and Dependent Care Expenses, available at www.irs.gov.

Please note that Publication 503 is intended for use on individual Federal Income Tax Returns and in some cases details in Publication 503 may not apply to flexible spending accounts such as the DCSA. If there is a conflict between any item in the DCSA section of this document and Publication 503, this section will govern.

INELIGIBLE EXPENSES UNDER THE DEPENDENT CARE SPENDING ACCOUNT

Examples of dependent and child care expenses that are not eligible for reimbursement, as defined by the IRS, include, but are not limited to:

- Care provided by an individual or agency not furnishing a Social Security or taxpayer identification number, unless the organization is tax-exempt.
- Care provided by your child, if under age 19, or by someone you claim as a dependent on your federal tax return.
- Care not related to your employment, such as non-work-related baby-sitting costs or expenses that enable you or your spouse to do volunteer work.
- Care on days when you are on vacation, except if your provider charges you to "keep your slot open" on days that your dependent is not present.
- Transportation expenses.
- Convalescent or nursing home costs.
- Educational expenses, such as tuition or books.
- Overnight camp expenses.
- Care for a domestic partner.

Note: Expenses for education are not eligible. However, charges for preschool and nursery school are eligible only to the extent they are for custodial care of the child rather than education. For advice on what portion of the charges can be attributed to child care in your specific case, contact your personal tax advisor.

HOW TO FILE A DEPENDENT CARE SPENDING ACCOUNT CLAIM

For specific claim instructions, including claim submission deadline, see "How to File a Claim" in the Administrative Information section.

Acclaris will reimburse your submitted claims to the extent that money is available in your account. As a result, you may receive partial reimbursements until your claim is paid in full. Reimbursements will be made directly to you and not to the service provider.

You may submit claims for reimbursement as often as you like for dependent care provided within the plan year, but only after the services have actually been provided. A minimum claim of $25 is required.

With each submission, you will need to attach a fully completed claim form along with a statement from the care provider which includes the date or period of service, the amount of the charge and the provider's name and Social Security or taxpayer identification number (unless the organization is tax exempt and this is noted on the statement). In most cases, claims will be processed within 3 business days from receipt.

A run-out period from January 1st through June 30th of the following year is provided to allow time for any outstanding claims from the previous year to be received and processed. Claims postmarked after June 30th for expenses incurred in the preceding plan year will be ineligible for reimbursement.

Account and claim payment information is available on the Acclaris web site or by calling Acclaris customer service.

Claims for services provided during the period you participated in the Plan (i.e., through the last day of the pay period for which the DCSA deduction was made) will be processed until your DCSA balance is depleted or until the following June 30th, whichever occurs first. Any money remaining in your DCSA account after that date will be forfeited. Reimbursed expenses are not eligible for reimbursement under any other plan. If you leave the IBM payroll during the plan year, for example, through an unpaid leave of absence, retirement or separation, your DCSA contributions will stop. Expenses for services provided during the period in which you were not contributing to the Plan are not eligible for reimbursement. If your participation ends before the end of the plan year — for example, if you leave IBM — you may be reimbursed for eligible expenses incurred after you leave and through the end of the plan year. (You can only submit eligible expenses that allow you and your spouse to work.)

FEDERAL TAX CREDIT

Expenses eligible under the DCSA are the same as those expenses eligible under the Child and Dependent Care Expenses Form 2441 of your federal income tax return. If you currently use the federal tax credit, you may be able to increase your savings by using the DCSA instead. Or, you may gain most from a combination of DCSA and the federal tax credit to the allowable limits. Your decision should be made after careful planning.

DEPENDENT CARE SPENDING ACCOUNT TESTING

In order to meet federal requirements for favorable tax treatment, the Plan must maintain certain relationships of eligibility and usage between highly and non-highly compensated employees. In the event it should become necessary, IBM may take actions to maintain this tax-favored status, such as limiting the contributions of highly compensated employees. If the Plan does not meet IRS guidelines, certain employees may be limited from contributing the full annual amount they elected. You will be contacted if this affects you.

The Plan may be modified or discontinued by IBM in the future based on the impact of possible tax law changes or legislative requirements.

TAX REPORTING

Your annual DCSA contribution is not included in your total wages, but this amount will be included on your federal W-2 form, indicated as "DCB" (Dependent Care Benefit). When filing your federal return, you will be required to report "DCB" and related expenses on Form 2441.

IBM Special Care for Children Assistance Plan

IBM Special Care of Children Assistance Plan

ABOUT THE SPECIAL CARE FOR CHILDREN ASSISTANCE PLAN

The IBM Special Care for Children Assistance Plan (SCCAP) is designed to help you meet expenses for certain treatment and therapy outside the scope of the coverage available under the IBM medical, dental, vision and behavioral health plan options for eligible children with mental, physical or developmental disabilities. "Outside the scope of coverage available" is treatment ineligible for any coverage under the IBM medical and dental plan options, or other coverage such as an HMO. In some cases, it is difficult to determine if services are outside the scope of coverage. In such cases, an Explanation of Benefits (EOB) indicating services are not covered services under the medical, dental, vision or behavioral health plans may be required for new or renewal requests for services.

You are eligible for this assistance only after you have received all aid available to you and your child from federal, state and other sources and that aid has been exhausted. Each case is individually reviewed to determine eligibility for assistance. If there is a mental health component of your child's developmental diagnosis, it should first be reviewed by the mental health claims administrator of your medical plan.

FOR MORE INFORMATION ABOUT THE PLAN

Call the IBM Benefits Center to request a Special Care for Children Assistance Plan brochure and application package, which includes information on the Plan, instructions for completing your application and the required forms.

Upon approval, SCCAP will cover a portion of the eligible charges incurred, up to a $50,000 lifetime maximum benefit, until the last day of the month in which the child turns age 26, or is no longer eligible under the IBM Plan, whichever occurs first.

WHO IS ELIGIBLE

Dependent children are eligible for benefits under the IBM SCCAP. For a definition of dependent children, see "Eligibility" in the About the Personal Benefits Program section. Please note that if your child becomes a ward of the state, the child is no longer considered an eligible dependent, and benefits are not payable.

When Your Child Turns Age 26

Even if a child is eligible for continuous coverage under the IBM Plan beyond the age of 26, the child will not be eligible for benefits under the IBM SCCAP beyond midnight on the last day of the month in which the child's 26th birthday occurs.

HOW THE PLAN WORKS

Reimbursement under the IBM SCCAP will be determined as follows:

Reimbursement Rates	
Annual Family Deductible*	$150
Separate from the IBM Medical Plan deductible	
Lifetime Maximum	$50,000 per eligible child
Treatment or Service	**Reimbursement**
Day Care or Residential Care Facility	80% of 75% of eligible charges
Outpatient Facility, Clinic or Independent Practitioner	80% of eligible charges
Special Devices	80% of eligible charges

* A $150 annual family deductible is applied after the reimbursement amount is established. Only expenses incurred in the same calendar year can be applied to your annual deductible, and all claims must be approved and received by the health plan by December 31st of the following year.

Medical and dental co-pays, co-insurance, deductibles, out-of-network charges, etc. are not eligible for reimbursement under SCCAP.

Outside Assistance

Outside assistance may be available from federal, state or other sources (such as a local school district or county department of social services). Such assistance is generally funded by tax revenues to which both you and the Company contribute. Therefore, the objective of SCCAP is to provide an extra benefit after you have received all other assistance to which you are already entitled.

In applying for such assistance, IBM benefits should not be considered in calculating the amount to be paid by you. Eligible charges will be reimbursed under the IBM SCCAP only if those charges are payable by you irrespective of the existence of this Plan.

The following calculations are used to determine benefit reimbursement when outside assistance is received:

How SCCAP Reimbursement Is Calculated When There's Outside Assistance	
Treatment	**Reimbursement Calculation**
Clinic and Outpatient Services *Reimbursed at 80% of eligible charges*	Eligible charges *minus* the amount of outside assistance received
Day and Residential Special Facilities Care *Reimbursed at 80% of 75% of eligible charges*	If outside assistance equals or exceeds the initial 25% reduction: ▪ Eligible charges minus the amount of outside assistance received, and the 25% reduction will not be applied If outside assistance is less than the initial 25% reduction: ▪ Outside assistance will not be used in the reimbursement calculation, and the initial 25% reduction will be applied to the entire amount of eligible charges

WHAT IS COVERED UNDER THE PLAN

Eligible Treatment Facilities

Eligible treatment facilities may include licensed clinics, day or residential special care facilities, special education facilities for the learning-disabled child and camps (where the program offered is medically

oriented and is part of the child's continued treatment for mental, physical or developmental disabilities). In order to be eligible for reimbursement, the care must be determined to be appropriate and the facility must meet both "1" and "2," and either "3" or "4" below:

1. Is medically oriented and operated under the supervision of a physician, psychiatrist or licensed Ph.D. clinical psychologist primarily for the rehabilitation or remediation of the child's condition of mental, physical or developmental disability.
2. Has a planned program for the rehabilitation or remediation of the diagnosed mental, physical or developmental disability which has been reviewed and approved and is supervised by a physician, psychiatrist or licensed Ph.D. clinical psychologist.
3. Has the approval of or meets minimum standards of applicable professional associations (for example, American Medical Association, American Psychiatric Association).
4. Is licensed or certified by or has the specific approval of applicable governmental agencies (for example, state or federal departments of health and/or mental hygiene).

Note: If a facility's program is not under the direct supervision of a physician, psychiatrist or clinical psychologist, the child's physician or psychiatrist must provide a letter of supervision indicating s/he will continue to be involved with the supervision of the child's treatment and review the child's progress on a regular basis.-For a school to be eligible, the school must offer a bona fide learning disability program.

Independent Practitioners and Eligible Conditions

Charges for necessary care and treatment by an independent practitioner will be considered for reimbursement when the practitioner is licensed or certified to practice in his or her particular field and when the practitioner is providing services for the child's diagnosed mental, physical, developmental or learning disabilities. The following are examples of some typical practitioners whose services are eligible under the Plan along with some typical conditions they may treat:

- Independent speech pathologist or audiologist who holds a certificate of clinical competence in speech-language pathology or audiology from the American Speech-Language-Hearing Association and/or licensed by the state to practice speech-language pathology or audiology. Typical conditions requiring treatment from a speech pathologist or audiologist are speech impairments, articulation disorders, myofunctional disabilities and tongue thrust associated with orthodontia.
- Nutritionists or dietitians who are certified as Registered Dietitians (RD) by the American Dietetic Association. Typical conditions requiring treatment from a nutritionist or dietitian are eating disorders such as anorexia nervosa and bulimia nervosa.
- Licensed/Certified/Registered physical or occupational therapists. Typical conditions requiring treatment from a licensed/certified/registered physical or occupational therapist are cerebral palsy and other related neuromuscular disorders with functional impairment or "developmental delay."
- Treatment by an orthodontist, when the orthodontia is part of an overall treatment program which includes the surgical correction of orthognathic or orofacial abnormalities.
- Treatment by an optometrist for visual impairments, where the condition is diagnosed as progressive myopia.
- Treatment for a diagnosed learning disability when rendered by a learning disability specialist. The practitioner must have a degree in education, hold a state license or certification to teach, with a background in special education and working with special needs children for a minimum of five years or have a master's degree in special education and hold a state license or certification to teach.
- Academic tutoring is not eligible for coverage under the Plan. Therefore, in order to make a distinction between a bona fide learning disability of a slow learner who may require academic

tutoring, it is a requirement of the Plan that the child undergoes psychological or psych-educational testing to support the learning disability condition. The results of this evaluation must be submitted as part of the Special Care application and must include a clearly documented diagnosis before any treatment program can be approved for benefits.

- The psychological testing must be administered by an independent psychiatrist, psychologist or school psychologist who is not affiliated with the provider of services.
- Approved cases require periodic psychological or psycho-educational testing every three years to evaluate the necessity for continuance of coverage.
- Charges for the psychological testing are eligible for benefits under the Plan if the reason for the testing is to determine whether a learning disability exists, regardless of the test results. If the reason for the psychological testing is other than to ascertain whether the child is learning disabled, charges may be eligible for benefits under the Managed Mental Health Care Program under the IBM Plan or any other health coverage you may have.

Note: Claims for psychological testing must first be submitted to the Managed Mental Health Care Program to determine if any charges are eligible under this program. Charges not eligible under the Managed Mental Health Care Program that are determined to be related to a learning disability can then be considered under SCCAP. SCCAP will not reimburse the deductible or the difference between in-network and out-of-network charges deemed to be eligible under the Managed Mental Health Care Program.

Note: Holistic, homeopathic and naturopathic treatments are not eligible under the SCCAP. Wilderness Programs are also not eligible for reimbursement under the SCAAP or the IBM Plan

Special Devices

Special devices will be considered for eligibility under the Plan only if the devices are:

- Prescribed by a physician and
- Provide either direct medical treatment of the child's condition of mental, physical or developmental disability or the device must improve the life functioning of the child by enhancing the ability to see, communicate or use his or her limbs.

For example, charges for a special vision aid (such as a prism) for severe loss or impairment of sight will be considered for reimbursement if ineligible under the employee's medical plan option. Charges for correction of nearsightedness, farsightedness or astigmatism are not eligible. (See the "IBM Vision Plan regarding routine examinations for the prescription or fitting of eyeglasses.)

Hearing Aids

Hearing aid devices may be eligible for IBM Medical Plan coverage as described in the "IBM Medical Coverage" section.

If a hearing aid benefit is not available through the employee's medical plan, hearing aids are eligible for coverage under SCCAP. Hearing aids will be reimbursed under SCCAP at 80%, after a $150 annual deductible, up to an individual annual maximum of $400, including repairs and batteries.

HOW TO APPLY FOR SPECIAL CARE BENEFITS

1. To apply for Special Care for Children Assistance Plan benefits, contact the IBM Benefits Center – Provided by Fidelity and request a SCCAP application package, which includes information on the Plan, instructions for completing your application and the required forms. SCCAP claim forms are available on NetBenefits. You must apply for coverage before submitting any claims.
2. Once you receive the application package, complete, sign and submit the following forms:

- Statement of Child's Physician, Psychiatrist or Clinical Psychologist — this form is required. This is sometimes called the doctor's recommendation form.
- Statement of Independent Practitioner or Special Care Facility — this form is completed by the independent provider or facility providing the treatment.

3. It may be necessary to provide additional documentation depending on the services being rendered:
   - For remediation for a learning-disabled child a psychological or psycho-educational evaluation must be submitted. These evaluations are considered valid for three years from the date of testing, and reevaluations must be presented for continuation of assistance. Psychological evaluations are employed to assess the cognitive development of children and to determine if a delay in development or a learning disability exists. Some of the tests included in a psychological evaluation are Stanford-Binet Form L-M (S-B), Wechsler Intelligence Scale for Children-Revised (WISC-R), Wechsler Preschool and Primary Scale of Intelligence (WPPSI) and the Bender Visual Motor Gestalt Test and Woodcock-Johnson.
   - When service is being rendered by a clinic, day or educational facility, a brochure describing the facility program and services must be provided and must demonstrate the facility has a program to treat the diagnosis.
   - The license or certificate of clinical competence is required for speech therapists/pathologists or audiologists who are in independent practice.
   - A brochure describing the device and its usage, and documenting that the device treats the diagnosis is required when applying for special devices.
4. Complete all forms and send them together with any required additional documentation to the IBM Benefits Center at the address listed on the forms in the application package. Incomplete forms or missing information (missing signature, diagnosis, date of service, provider credentials, etc.) will be returned. This will delay the review process.
5. Special Care for Children Assistance Plan benefits are considered on an annual basis. You must reapply for coverage each year.

If approved, you will receive an authorization for benefits. You may submit bills for charges before services are rendered when payment in advance is a requirement of the facility. However, you should not submit bills prior to 30 days from the start date or 30 days prior to the date the fees are due.

Only expenses incurred in the same calendar year can be applied to the annual deductible. All approved claims for benefits and supporting documentation must be received by Anthem Blue Cross and Blue Shield by December 31st of the year after the charges were incurred. It is the employee's responsibility to submit claims to Anthem.

Where advance reimbursement has been made and your child is subsequently withdrawn from the program or where fees are reduced, you must advise the IBM Benefits Center, since you are responsible for any overpayments made.

You have a responsibility to ensure the accuracy and validity of all bills submitted for payment, to pay the providers of service the amount due them on a timely basis and to advise IBM of any discounts or price adjustments made by the providers.

Note: Eligibility of services other than those described above should be discussed with the SCCAP Administrator at the IBM Benefits Center – Provided by Fidelity.

The chart below documents which forms need to be completed for various services.

SERVICES	SCCAP FORMS
Psychological Evaluation	▪ Doctor Form ▪ Provider Form and/or paid invoice ▪ EOB (Explanation of Benefits) denying services from Behavioral Benefits Carrier, OR Pre-authorization Denial Letter from the Carrier
Occupational, Physical Therapy or Speech Evaluation	▪ Doctor Form ▪ Provider Form ▪ EOB (Explanation of Benefits) from Medical Carrier
Treatment for a learning disability	▪ Doctor Form ▪ Provider Form ▪ Current Neuro-Psych Evaluation
Therapy for a developmental disorder	▪ Physician Form ▪ Practitioner Form ▪ Other documents may be required upon review
Therapy when diagnosis is both developmental and mental disorders	▪ Doctor Form ▪ Provider Form ▪ EOB (Explanation of Benefits) from mental health carrier
Special Care Facility	▪ Doctor Form ▪ Provider Form ▪ Evaluation (if facility is for treatment of learning disability, an evaluation is also required) ▪ Documentation on how the facility treats the diagnosis ▪ Other documents may be required upon view
Special Device	▪ Doctor Form ▪ Provider Form and/or Invoice ▪ Documentation on how the device treats the diagnosis ▪ Other documents may be required upon review

CONVERTING YOUR COVERAGE

There is no conversion privilege under the Plan. Individuals who lose eligibility for coverage may purchase equivalent coverage for a time through the Transitional Medical Program (TMP) administered by the IBM Benefits Center – Provided by Fidelity. For more information, see "Transitional Medical Program (TMP)" in the Administrative Information section or contact the IBM Benefits Center.

IBM Adoption and Surrogacy Assistance Program

IBM Adoption and Surrogacy Assistance Program

ABOUT THE IBM ADOPTION AND SURROGACY ASSISTANCE PROGRAM

The IBM Adoption and Surrogacy Assistance Program provides some financial assistance toward expenses incurred in the attempt to either adopt a minor child/children or have a child/children through surrogacy. Your eligibility for coverage begins on your first day of employment. IBM pays 100% of eligible expenses related to the adoption of a minor child/children or the attempts to have a child/children through surrogacy, up to a lifetime maximum of $20,000 per family. Note that under current tax law, only $14,080 of this amount can be excluded from your income.

Transition Rule- If you adopted a child on or after November 1, 2016, all eligible expenses related to the adoption of that child, are eligible for reimbursement, up to the lifetime maximum of $20,000. Furthermore, any incurred adoption or surrogacy expenses on or after November 1, 2016, irrespective of placement of a child, is also eligible for reimbursement, up to the lifetime maximum of $20,000. These expenses must be submitted no later than December 31of the year after the year the expenses were incurred or the year the child was placed. Any additional eligible expenses you submit, when combined with expenses previously submitted, cannot exceed the lifetime maximum of $20,000.

ADOPTION AND SURROGACY ASSISTANCE PROGRAM ADMINISTRATOR

The administrator for the Adoption and Surrogacy Assistance Program is Acclaris.

Customer Service Availability
Acclaris representatives are available to assist you with claim questions Monday through Friday from 8 a.m. to 8 p.m., Eastern time.

You can reach an Acclaris representative at 888-880-2775 or online at www.acclarisonline.com. Forms can be submitted to Acclaris PO Box 25171, Lehigh Valley, PA 18002-5171

Who Is Eligible

You're eligible if you are a regular full-time or part-time IBM employee, or an active IBM employee on leave of absence with benefits, or an IBM employee on disability (Long Term Disability or Medical Disability Income Plan). Reimbursement claims must be submitted no later than December 31 of the year after the year in which expenses are incurred; otherwise no benefit will be payable.

Note: If you and your spouse are both IBM employees, only one of you may submit a claim. The plan provides reimbursement up to $20,000 lifetime maximum per family.

How the Program Works

The IBM Adoption and Surrogacy Assistance Program provides some financial assistance toward expenses incurred in the adoption of minor children. For eligibility under the program, the child must be below the age of majority (as defined by the law of the state in which the adoption occurs) on the date of placement. The Adoption and Surrogacy Assistance Program covers the adoption of:

- Unrelated minor children
- Foreign minor children
- Minor children of relatives
- Minor stepchildren

- Minor twins or multiple children
- The program also covers surrogacy arrangements and embryo adoptions.

Note: Adopted children will be eligible for IBM health benefits once they've been ***placed*** *in your home. A child is considered "placed" when the adoptive parent(s) or parents through a surrogate receive legal custody of the child. You have 30 days from the date of this placement to add your new dependent to your IBM health coverage.*

WHAT'S COVERED UNDER THE PROGRAM

- Application fee
- Adoption or surrogacy agency fees
- Placement fees
- Lawyers and other required legal fees
- Medical expenses of the surrogate, including In Vitro Fertilization (IVF), whether or not the IVF attempt results in a birth
- Hospital expenses while both birth mother and infant are in the hospital
- Temporary foster care charges (immediately preceding placement with adopting family

There need not be a legal placement of a child in order for the above expenses to be eligible for reimbursement.

WHAT'S NOT COVERED UNDER THE PROGRAM

Ineligible expenses include personal items for the child, travel expenses, voluntary donations or contributions and legal fees to obtain guardianship or custody of one's own child.

How to Apply for Reimbursement

For information or to receive an IBM Adoption and Surrogacy Assistance Program claim form, contact the IBM Benefits Center or access w3. Claim forms are also available on NetBenefits or from the Acclaris website.

You may submit your claim form as soon as incur eligible expenses. Submit one claim form for each adopted child/child through surrogate.

If you and your spouse are both IBM employees, only one of you may submit a claim. The plan provides reimbursement up to $20,000 lifetime maximum per family.

To file a claim:
Complete the claim form and attach all itemized bills and supporting documentation (including proof of payment). Submit these to Acclaris at the address on the form.

- All claims and supporting documents must be received by Acclaris no later than December 31st of the following year in which the expense was incurred; otherwise, there will be no benefit payable.
- Reimbursement of eligible claims will be provided monthly to active employees via their pay; to other eligible individuals (employees on leave of absence with benefits or MDIP/LTD) via check mailed directly to the home address. Actual payment of claims will be made following your receipt of an Explanation of Benefits (EOB) statement from Acclaris. All questions regarding claim payments should be directed to Acclaris.

Notes:

- The IBM Adoption and Surrogacy Assistance Program is not a qualified plan for purposes of the Internal Revenue Code. All adoption and surrogacy expenses which are reimbursed under the program are reported to the IRS by IBM as compensation subject to the appropriate federal, state and local withholding taxes. Therefore, when you receive your W-2 for the previous tax year, box 13 is not populated with a "T" because it is taxable income.
- Under tax law, you may be able to receive tax-favored treatment for qualified adoption expenses. You may want to consult your personal tax advisor prior to incurring adoption expenses and submitting for reimbursement under IBM's Adoption Assistance Program.

Personal Financial Planning — IBM Money*Smart*

Personal Financial Planning – IBM Money*Smart*

ABOUT IBM MONEY*SMART*

IBM Money*Smart* is an innovative program providing financial education and planning for all U.S. employees. The program was designed specifically for IBM employees and includes

- One-on-one telephone counseling with a Money*Smart* Coach
- Educational webinars – informative and most only 30 minutes long
- Interactive Web portal – online modeling and planning tools

By partnering with two leading financial services firms — The Ayco Company, L.P., a Goldman Sachs Company, and Fidelity Investments — IBM Money*Smart* can help you take charge of your financial future.

Financial Planning — A Shared Responsibility

Much as we would like to believe that our employer and the government will take care of our financial future, it just isn't so. Today, more than ever, United States employees are becoming active partners with their employers and the federal government to develop comprehensive financial strategies. These responsibilities must be shared, for example:

- Employer (IBM): provides a broad package of benefits and programs that serves as the foundation for meeting many of your personal objectives.
- Federal Government: provides income tax incentives and direct payment programs, such as Social Security payments.
- Individual (You): actively manages his or her financial future. Understands personal objectives to design a well-thought-out financial plan. Consults with professional financial planners, as needed. Stays current on government regulations since tax rules change often and can affect areas such as college education funds, retirement planning and estate accumulation.

WHO IS ELIGIBLE

All IBM U.S. based regular full-time and regular part-time employees (including those on a leave of absence or on international assignment), Supplemental 2 and Retiree Supplemental employees are eligible for the IBM Money*Smart* program. Additionally, certain employees who have separated from IBM (and certain other individuals) may continue to receive one-on-one counseling from both Fidelity Investments and The Ayco Company for 120 days past the employee's last day of work (or death), limited to the following:

- retired employees who registered for the program before they retired
- employees affected by a resource action
- surviving spouse and domestic partners of deceased employees

Surviving spouse and domestic partners will have access to Money*Smart* coaches for the 120-day extension period if the employee had registered with the Money*Smart* program prior to his or her death. Retired employees will have access to Money*Smart* coaches for the 120-day extension period if the employee had registered with the Money*Smart* program prior to his or her retirement. If an employee leaves IBM as the result of a resource action, they will have access to Money*Smart* coaches for the 120-day extension period. If they had not previously registered, Ayco will ensure they register over the phone prior to providing services.

IBM MONEY*SMART* SERVICES

Money*Smart* offers IBMers a highly personalized experience. Every employee — from novice to savvy investor — will find something of value in the program's offerings. You can attend an educational seminar, schedule confidential, one-on-one financial counseling sessions with a Money*Smart* Coach trained on IBM benefits and use the helpful resources and tools on the Money*Smart* Portal.

Coaching

Provides IBM employees the opportunity for unlimited one-on-one counseling over the phone with IBM Money*Smart* coaches. Highlights include:

- Coaches trained in IBM programs and benefits
- Confidential
- No preparation required
- Unlimited access
- Your spouse/domestic partner can call with your permission

Topics You Might Discuss with your Money*Smart* Coach:

- Prioritizing your financial issues
- General financial planning concerns
- Cash flow and personal goal setting
- Insurance
- Estate planning
- Income taxes
- Investment planning
- IBM benefit plans
- Retirement income planning – if you are nearing retirement, your Money*Smart* Coach will connect you with a retirement specialist

Webinars

Educational webinars available on a variety of topics. Most webinars are generally only 30 minutes long and you can sign up for one or more at a time through the IBM Money*Smart* portal. Spouses/domestic partners are invited to attend.

Web Portal

This IBM Money*Smart* portal includes online modeling and planning tools. Access the Money*Smart* portal to view and sign up for any upcoming financial planning webinars. The portal is available 24/7 and is easily accessible through w3 by going to http://w3.ibm.com/hr/us/moneysmart.

HOW TO GET STARTED

Register at http://w3.ibm.com/hr/us/moneysmart,
Or
schedule a one-on-one phone consultation with a Money*Smart* Coach.

For broad based financial counseling, call an Ayco coach at 877-543-7678 (hearing impaired: 866-217-8694) Monday-Friday, 9 am to 8 pm Eastern time.

For retirement planning, call a Fidelity coach at 800-976-1054 (hearing impaired 800-544-0118) Monday-Friday, 8 am to 8 pm, Eastern time.

Legal Information

Legal Information

YOUR RIGHTS UNDER HIPAA

The Department of Health and Human Services has issued federal regulations regarding the privacy of individual health records. These regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The purposes of this law (referred to as the "Privacy Rule") are to standardize and safeguard the transmission of protected health information, to protect the privacy of individual health information and to allow individuals to access their medical records.

The HIPAA Privacy Rule applies to the IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees (the "Plan"), including the Plan's medical, dental, vision, employee assistance and health care spending account programs. The Privacy Rule is effective as of April 14, 2003.

Health Information Protected by the HIPAA Privacy Rule

The HIPAA Privacy Rule applies to "Protected Health Information" (PHI). PHI is individually-identifiable health information that is created or received as part of administering the Plan. PHI includes information that (1) identifies, or can be used to identify, you, (2) is created or received by a health care provider, health plan, or employer, and (3) relates to your past, present and future physical or mental condition, and the provision of health care and payment for that care.

Uses and Disclosures of Protected Health Information by the Plan

The Plan may use or disclose PHI for purposes of treatment, payment, health care operations or as authorized by you. Information may also be disclosed in order to comply with federal, state or local law and to avert a safety threat to you or the public. When protected information is used or disclosed, even for purposes of treatment, payment or health care operations, only the minimum amount of information determined necessary to achieve the task will be used or disclosed.

Your Rights Under the HIPAA Privacy Rule

- Your protected health information will be kept private and will not be used or disclosed other than as permitted under the HIPAA Privacy Rule or as required by law.
- Your protected health information will not be used for unrelated purposes, such as making employment-related decisions or decisions related to other IBM benefit plans, unless specifically authorized by you or as required by law. (You may limit or revoke an authorization at a later time.)
- You have the right to inspect and obtain a copy of certain designated medical records, if such records are maintained by the Plan, and to request changes to those records.
- You have the right to request a listing of the Plan's uses and disclosures of your PHI (other than for purposes of treatment, payment and healthcare operations as described above).
- You have the right to request a restriction or limitation on how the Plan can use or disclose your private medical information for purposes of treatment, payment or health care operations. The Plan will consider but is not required to agree to your request.
- You have the right to request that the Plan's communications with you about your PHI are made in a certain way or at a certain location if your request states that communication in another manner may endanger you. The Plan will accommodate reasonable requests.
- You have the right to be notified if the plan discovers a breach of unsecured PHI.

If you wish to request an opportunity to inspect or obtain a copy of your PHI, an amendment of your PHI, a listing of the Plan's uses and disclosures of your PHI, a restriction or limitation on uses and disclosures of your PHI or a particular means of communication, and your request pertains to PHI maintained by the Plan at the IBM Benefits Center – Provided by Fidelity, submit your request in writing to:

IBM Benefits Center
PO Box 770003
Cincinnati OH 45277-1060

For requests pertaining to PHI maintained by a Plan Administrator for a medical, dental, vision or other option within the Plan, submit your request in writing to the applicable plan(s) at their address listed in "Plan Funding and Administration Chart" later in this section.

IBM's Responsibilities Under the HIPAA Privacy Rule

The Plan may disclose PHI to IBM, as the Plan Sponsor, for purposes of administering the Plan. In order to receive this information, IBM must certify to the Plan that it will: (a) comply with the HIPAA Privacy Rule, (b) only use and disclose PHI as required by law or for the permitted purposes described on the previous page, (c) only use and disclose the minimum amount of information determined necessary to achieve the task and (d) report to the Plan any violations of these requirements.

Any disclosure of PHI by the Plan to IBM will be limited to only those IBM employees who are directly involved in the administration of the Plan (which may include employees in the Human Resources/ Benefits, Internal Audit/Business Controls and Legal functions with responsibility for matters relating to Plan administration) and to those subcontractors of IBM who have been retained for purposes of administering the Plan (such as a health Plan Administrator for one of the Plan options). Unless authorized by you or required by law, these employees and subcontractors will only use or disclose PHI for purposes related to treatment, payment or health care operations under the Plan and will implement reasonable and appropriate security measures to protect the information. Any employee who uses or discloses PHI for any other purpose will be subject to disciplinary action. The Plan will notify you in the event of any breach involving unsecured PHI. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

Additionally, IBM has agreed to: (a) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule, and (b) if feasible, return or destroy all PHI received from the Plan and retain no copies of PHI when it is no longer needed or, if not feasible to return or destroy PHI, to safeguard and limit the use and disclosure of the PHI as required by law and (c) implement administrative, physical, and technical safeguards (within the meaning of 45 C.F.R. § 164.304) that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI (as defined in 45 C.F.R. § 160.103) that IBM creates, receives, maintains, or transmits on behalf of the Plan.

Concerns About the Handling of Your Protected Health Information

If you believe your rights under the HIPAA Privacy Rule have been violated, you may file a written complaint with the Plan or with the Department of Health and Human Services.

The plan has designated at Chief Privacy Officer at IBM, who is responsible for developing, communicating and enforcing the necessary procedures for ensuring the privacy of PHI. The IBM Chief Privacy Officer is the Plan's first point of contact for handling a complaint. The IBM Chief Privacy Officer will investigate the details of your complaint, and will respond to you with the results of the

investigation. To file a complaint with the Plan, please contact: IBM Chief Privacy Officer 1 New Orchard Road, Armonk NY 10504 Attn: HIPAA Privacy. All complaints must be submitted in writing. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also contact the Department of Health and Human Services at the Office of Civil Rights for the region where the alleged violation occurred. Contact information for regional offices of the Office of Civil Rights is available at https://www.hhs.gov/ocr/about-us/contact-us/index.html.

Additional Information

A complete description of your rights under the HIPAA Privacy Rule, including examples of permitted uses and disclosures of PHI, can be found in the Plan's Health Information Privacy Notice. The Notice was distributed to all employees covered by the Plan on October 11, 2013 (or upon becoming eligible, whichever is later). A copy of the Notice is also available on w3, NetBenefits or by calling the IBM Benefits Center – Provided by Fidelity.

CLAIMS

In order to receive benefits under the plans described in this book, you or your health care provider must submit a claim to the Claims Administrator for the applicable health plan under which you are seeking a benefit. For the IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees, you must submit your claim to the Claims Administrator for the particular medical, vision, or dental option under which you are seeking a benefit. For ease of discussion in this section, these plan options are also referred to as "plans." For purposes of this section, a "claim" means (1) a request for a plan to pay benefits covered under the plan or (2) a request for the plan to reinstate your coverage after a rescission of coverage (*i.e.*, a retroactive cancellation of your coverage for reasons other than your failure to timely pay contributions toward the cost of coverage). Requests for a determination regarding whether you or another person are eligible to participate in a plan must be submitted to the Plan Administrator in accordance with the procedures described in "Eligibility".

Each plan described in this book provides an internal claim and appeal process administered by the Claims Administrator and Appeals Administrator for the particular plan and the IBM Plan Administrator. If the plan under which you are seeking a benefit is subject to the Patient Protection and Affordable Care Act (the formal title of the federal health reform law) and is not "grandfathered" under the Act, claims that are denied on final internal appeal are eligible for external review by an independent review organization. (See "Plan Funding and Administration Chart" to determine whether your plan is subject to the Patient Protection and Affordable Care Act.)

Claims for Non-Health Benefits

For claims for benefits that are not health benefits, unless special circumstances require an extension of time for processing the claim, the Claims Administrator will notify you or your authorized representative of its decision within 90 days after the Claims Administrator receives the claim. If an extension is necessary, the Claims Administrator will notify you or your authorized representative before the expiration of the initial 90-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. In no event may the extension exceed 90 days from the end of the initial period.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 60 days after receiving notice of a denied claim for non-health benefits. (See "Plan Funding and Administration Chart" for the plans' appeals addresses.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Post-Service" Health Claims
Post-service health claims are claims for health benefits that did not require advance approval from the plan.

The Claims Administrator will provide notice of the plan's final decision within 30 days after receipt of a post-service health claim. However, if the Claims Administrator needs more time to make a determination due to matters beyond its control, the Claims Administrator will notify you or your representative of the need for additional time within 30 days after receiving the claim. This notice will include the reason for the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information and will resume on the date you or your representative responds to the notice.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied post-service health claim. (See "Plan Funding and Administration Chart" for the plans' appeals addresses.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Pre-Service" Health Claims
Pre-service health claims are claims for health benefits that require advance approval from the plan.

The Claims Administrator will provide notice of the plan's final decision within 15 days after receipt of the pre-service health claim. However, if the Claims Administrator needs more time to make a determination due to matters beyond its control, the Claims Administrator will notify you or your representative of the need for additional time within 15 days after receiving the claim. This notice will include the reason for the extension and the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information and will resume on the date you or your representative responds to the notice.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied pre-service health claim. (See "Plan Funding and Administration Chart" for the plans' appeals address.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Urgent Care" Health Claims
Urgent care health claims are claims for health benefits which if not received (1) could seriously jeopardize your life, health, or ability to regain maximum function or (2) in the opinion of the attending physician, cause you severe pain which cannot be managed without the requested services. If the attending physician determines the claim is an urgent care health claim, the Claims Administrator will treat the claim as an urgent care health claim.

The Claims Administrator will evaluate and respond to urgent care health claims within 72 hours after receiving the urgent care health claim. However, if necessary information is missing from the claim, the Claims Administrator will notify you or your representative within 24 hours after receiving the claim to specify the information that is needed. You or your representative must provide the specified information to the Claims Administrator 48 hours after receiving the notice. The Claims Administrator will notify you or your representative of the expedited benefit determination within 48 hours after you or your

representative responds to the notice or within 48 hours after requesting the information, whichever occurs first. Expedited notices of determinations may be provided orally, followed within three (3) days by written or electronic notification.

Upon receiving notice of a denied claim for urgent health benefits, you or your authorized representative may file an expedited appeal with the Appeals Administrator of the applicable plan orally, by phone or by facsimile.

Concurrent Care Health Claims

These are health claims to extend the approval for an ongoing course of treatment that has already been approved. You or your representative must submit a concurrent care health claim to the Claims Administrator at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative submits a concurrent care health claim, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the request.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied concurrent care health claim. Appeals received after this time will not be eligible for review under the internal appeals procedures.

Notification of Denial

If a claim for plan benefits is denied in whole or in part, the Claims Administrator for the applicable plan denying the claim will send you a written notice of the denial. This notice will include (1) the specific reasons for the denial; (2) references to the provisions of the plan on which the denial is based; (3) a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed; and (4) an explanation of the procedure to appeal the denial, including the time limit applicable to such procedure, and a statement of your right to bring a civil action under section 502(a) of ERISA if the claim is denied upon review.

In addition to the information required above, a notice denying a claim for health benefits will include the following additional information: (i) information sufficient to identify the claim involved, including, to the extent available, the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, (ii) the denial code and its corresponding meaning, and a description of the standard, if any, that was used in denying the claim, (iii) a description of the plan's procedure for requesting external review of claims, including information regarding how to initiate an external review, (iv) contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Labor to assist individuals with the internal claims and appeals and external review procedures, (v) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit, (vi) in the case of a health claim involving urgent care, a description of the expedited review process applicable to such claim, and (vii) such other information as the Claims Administrator determines is required by the Patient Protection and Affordable Care Act or other applicable law.

Note: The items described in (i), (ii), (iii), (iv), and (vii), may not be included in a notice responding to your claim for health benefits under a plan that is exempt from the Patient Protection and Affordable Care Act or is "grandfathered" under the Act. (See "Plan Funding and Administration Chart" to determine whether your plan is exempt from, or is "grandfathered" under, the Patient Protection and Affordable Care Act.) In addition, these items may not be included in a notice responding to your claim for health benefits under a plan that is subject to the Patient Protection and Affordable Care Act before January 1, 2012.

APPEALS

If your claim for benefits is denied, in whole or in part, you have the right to appeal the denial. An authorized representative may file the appeal on your behalf. There is only one level of appeal for denials of (1) urgent care health claims and (2) claims that are not for health benefits. IBM has a two-step internal appeals procedure for denials of health claims that are not urgent care health claims.

If your claim is subject to two levels of appeal, (1) the level-one appeal follows your initial claim denial and the level-two appeal follows the level-one appellate decision, and (2) except for claims under SCCAP, you must exhaust both levels of appeal before you have a right to bring a civil action or pursue an external review of the decision (if external review is available – see the "External Review" section, below). For claims under SCCAP you must exhaust only the level-one appeal before you have a right to bring a civil action.

The level-one appeal (or the appeal for claims that are entitled to only one appellate review) will be administered by the Appeals Administrator for the applicable plan. (See "Plan Funding and Administration Chart" for the plans' appeals addresses.) The level-two appeal will be administered by the IBM Plan Administrator except for Active Dental Appeals, which will be administered by the applicable plan.

For those enrolled in a plan option through Via Benefits, level one appeals regarding HRA claim denials or other HRA-related disputes will be handled by Via Benefits. The level-two HRA claim appeal will be administered by the IBM Plan Administrator. Appeal instructions will be sent to you by Via Benefits. For all other appeals, those should be directed to the health plan in which you are enrolled.

Filing An Appeal

A request for appeal must be filed with the Appeals Administrator or the IBM Plan Administrator, as applicable. Except as described in the following paragraph for appeals regarding urgent care health claims, the request for appeal must be in writing and include the reason why you feel your claim should be approved, any information supporting your appeal, and any information required by the Appeals Administrator or the IBM Plan Administrator, as applicable. You may submit written comments, documents, records, and other information relating to the claim. The Claims Administrator or Appeals Administrator, as applicable, will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

You may submit an oral or written request for an expedited appeal of a denial of an urgent care health claim. For an expedited appeal of an urgent care health claim, all necessary information will be transmitted between you and the Appeals Administrator by telephone, facsimile, electronic mail, or other available similarly expeditious methods.

Deadline for Filing An Appeal

An appeal for a claim denial for benefits other than health benefits must be filed within 60 days after you or your authorized representative receives notice of the initial claim denial. For an appeal related to a claim for health benefits, the 60-day period will be extended to 180 days. If you (or your authorized representative) fail to file a request for an appeal by the applicable deadline, you will have waived your right to appeal the denial.

Appeal for Denial of Non-Health Benefits

For appeals for benefits that are not health benefits, unless special circumstances require an extension of time for processing the appeal, the Appeals Administrator will notify you or your authorized representative of its decision within 60 days after the Appeals Administrator receives the written request for appeal. If an extension is necessary, the Appeals Administrator will notify you or your authorized

representative before the expiration of the initial 60-day period. The notice will indicate the circumstances requiring the extension and the date by which the Appeals Administrator expects to render a decision. In no event may the extension exceed 60 days from the end of the initial period.

Appeal for Denial of Health Benefits

Post-Service Health Appeals

The Appeals Administrator will respond in writing with a decision within 30 calendar days after it receives an appeal for a post-service health claim determination. After receiving notice of a denied post-service health claim on appeal, you or your authorized representative may file a written appeal with the IBM Plan Administrator within 180 days. Notification of the final decision by the IBM Plan Administrator will be provided within 30 calendar days after it receives the request for appeal.

Pre-Service Health Appeals

The Appeals Administrator will respond in writing with a decision within 15 calendar days after it receives an appeal for a required pre-service health claim. After receiving notice of a denied pre-service health claim on appeal, you or your authorized representative may file a written appeal with the IBM Plan Administrator within 180 days. Notification of the final decision by the IBM Plan Administrator will be provided within 15 days after receipt of the request for appeal.

Urgent-Care Health Appeals

The Appeals Administrator will respond orally to an appeal of an urgent care health claim with a decision within 72 hours, followed up in writing. This is the final step in IBM's internal appeals process for urgent care health claims. (See the "External Review" section below to determine whether you may submit the decision to an independent review organization for external review.)

Concurrent Care Appeal

An appeal of a concurrent care health claim denial will be classified as either an urgent care health claim, a post-service health claim, or a pre-service health claim, depending on the nature of the claim. Based on this classification, the applicable deadlines described above for urgent care health claims, post-service health claims, or pre-service health claims will apply to the concurrent claim appeal.

Procedures for Making Decision on Appeal

A decision on appeal will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination or level-one appeal decision. The Appeals Administrator's or IBM Plan Administrator's, as applicable, review of a claim will not afford deference to the initial claim denial decision or any level-one appeal decision and will be made by someone who was not involved in the initial claim decision.

If the plan has denied an appeal for health benefits based on a medical judgment (e.g., medical necessity, experimental/investigational), the Appeals Administrator or IBM Plan Administrator, as applicable, will consult with a health care professional with appropriate training and experience in the relevant field, who is not the individual who was consulted in connection with the initial claim denial or level-one decision regarding the claim or a subordinate of such individual. In this case, you may be asked to complete a Release of Information (ROI) allowing the health care professional to review your medical records and contact your physician.

By filing an appeal for health benefits with the IBM Plan Administrator (or, as a result of a filing on your behalf by your authorized representative), you acknowledge that the IBM Plan Administrator may receive and use information from the applicable plans related to your claim for benefits, for purposes of reviewing and rendering a decision on your appeal. The Health Insurance Portability and Accountability Act (HIPAA) rules will apply to the IBM Plan Administrator's use of such information (see "Your Rights Under HIPAA").

If the applicable plan is subject to the Patient Protection and Affordable Care Act and is not "grandfathered" under the Act, the Appeals Administrator will notify you of any (1) new or additional evidence considered, relied upon, or generated by the plan in connection with your claim or (2) any new or additional rationale for denying your claim, sufficiently in advance of issuing the notice of its determination to give you or your authorized representative an opportunity to respond.

Effect of Decision on Appeal

The decision of the Appeals Administrator for (1) urgent care health claims, (2) claims that are not for health benefits, and (3) appeals for benefits under SCCAP (if you choose not to pursue a level-two appeal for your SCCAP claim), is final and binding on all parties, including you and any of your beneficiaries under the plan. The decision of the IBM Plan Administrator for non-urgent care appeals or voluntary level-two appeals for benefits under SCCAP is final and binding on all parties, including you and any of your beneficiaries under the plan.

Notification of Determination on Appeal

If an appeal for plan benefits is denied in whole or in part, the Appeals Administrator for the applicable plan deciding a single level or level-one appeal or the IBM Plan Administrator deciding a level-two appeal will send you a written notice of its determination. This notice will include (1) the specific reasons for the decision, (2) references to the provisions of the plan on which the decision is based, (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, and (4) a statement that you might have a right to bring a civil action under section 502(a) of ERISA after exhaustion of the final appeal.

In addition to the information required above, a notice denying an appeal for health benefits will include the following additional information: (i) information sufficient to identify the claim involved, including, to the extent available, the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, (ii) the denial code and its corresponding meaning (if available), and a description of the standard, if any, that was used in denying the appeal and a discussion of the decision, (iii) a description of the plan's procedures for appealing a level-one appeal and requesting external review of claims, including the time limits applicable to such procedures and how to initiate such procedures, (iv) contact information for any applicable office of health insurance consumer assistance or ombudsman established by the Department of Labor to assist individuals with the internal claims and appeals and external review procedures, (v) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit, (vi) if required under section 503 of ERISA, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and our state insurance regulatory agency," and (vii) such other information as the Appeals Administrator or IBM Plan Administrator determines is required by the Patient Protection and Affordable Care Act or other applicable law.

Note: The items described in (i), (ii), (iii) (regarding the external review process), (iv), and (vii), may not be included in a notice responding to your appeal for health benefits under a plan that is exempt from the Patient Protection and Affordable Care Act or is "grandfathered" under the Act. (See " Plan Funding and Administration Chart" to determine whether your plan is exempt from, or is "grandfathered" under, the Patient Protection and Affordable Care Act.) In addition, these items may not be included in a notice responding to your claim for health benefits under a plan that is subject to the Patient Protection and Affordable Care Act before January 1, 2012.

EXTERNAL REVIEW

If you are not satisfied with the final decision on internal review or if you do not timely receive a decision on internal review, you may be able to request an external review of your claim by an independent third party, an independent review organization (IRO), who will review the denial and issue a final decision. IROs are separate companies that are not controlled by or associated with IBM, the Claims Administrators, or the Appeals Administrators.

Note: The External Review process described in this section applies to IBM's health plans that are subject to the Patient Protection and Affordable Care Act and are not grandfathered under the Act. External review is not available for IBM's health plans that are exempt from, or are grandfathered under, the Patient Protection and Affordable Care Act. (See "Plan Funding and Administration Chart" to determine whether your health plan is subject to the Patient Protection and Affordable Care Act.)

Types of External Review

There are two types of external review: Standard External Review and Expedited External Review.

Standard External Review:

You may request a Standard External Review, if you satisfy all of the following:

- your claim does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, (claims for eligibility under the plan are not subject to external review) and
- your claim (if filed for external review on or after September 20, 2011), involves medical judgment or a rescission of coverage (i.e., a retroactive cancellation of your coverage for reasons other than your failure to timely pay contributions toward the cost of coverage) and
- you were covered under the health plan at the time the health care item or service was requested or, in the case of retrospective review, at the time the health care item or service was provided and
- you (1) completed all levels of internal appeal for the claim denial (for reasons other than eligibility) and the claim denial was upheld or (2) during the internal claim or appeal process, the Claims Administrator, Appeals Administrator, or IBM Plan Administrator failed to adhere to the procedures outlined in the "Claims and Appeals" sections, provided that your claim will not be eligible for external review due to such a failure if the failure was de minimis, and (a) did not cause prejudice or harm to your claim, (b) was attributable to good cause or due to matters beyond the control of the Claims Administrator, Appeals Administrator, or IBM Plan Administrator, and (c) occurred in the context of an ongoing, good faith exchange between you and the Claims Administrator, Appeals Administrator, or IBM Plan Administrator and
- you provide all of the information and forms required to process an external review of your claim.

Expedited External Review:
If you have met the eligibility criteria for a Standard External Review, you may be eligible to file an Expedited External Review if you satisfy one of the following requirements:

- If you receive a claim denial that:
  1. is for an urgent care claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function and

  2. you have appealed the denial of the urgent claim to the appropriate Appeals Administrator.

- If you receive a final internal appeal decision and either:
  1. the appeal involves urgent care for a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function or

  2. the final decision on appeal concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

How to Request an External Review
IBM's external review process is managed by IPRO (Independent Peer Review Organization). IPRO maintains contracts with at least three (3) IROs to review eligible external review requests and assigns requests among the IROs on a random and unbiased basis. The IROs are independent from the Claims Administrators, Appeals Administrators, and IBM and only the IROs make External Review determinations.

To file a request for a Standard External Review, you or your authorized representative should send a letter to IPRO (at the address shown below) with (1) your name, telephone number and ID Number, (2) the claim number, (3) the date of service, (4) a description of your claim, (5) a copy of the denial letter and (6) any other information requested by IPRO:

IPRO
Corporate Programs
1979 Marcus Ave.
Lake Success, NY 11042-1002
Attention: IBM External Review Process

To file a request for an Expedited External Review, please contact IPRO by phone (516-326-7767 ext. 223), by facsimile (516-326-1034) or by e-mail (tgiorgio@ipro.org). You should provide (or will be asked to provide) all of the information required above for a Standard External Review and any other information you would like to have considered in connection with the Expedited External Review. IPRO will determine whether your claim is eligible for Expedited External Review.

Your request for an External Review must be received by IPRO within four months after the receipt of a notice of the denial of your final internal appeal. If no date corresponds to the date that is four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a weekend or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

The External Review Process

Standard External Review Process

Within five business days from the receipt of the request for a Standard External Review, IPRO will complete a preliminary review of your request in order to determine your eligibility for an External Review. Within one business day after completion of the preliminary review, IPRO will issue you or your authorized representative (and the independent review organization) a written notification of your eligibility for an External Review. If your request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to make the request complete. You will have an opportunity to complete the request within the four-month filing period, provided that if this period has already ended, you will be given 48 hours to respond to the request.

IPRO will assign an eligible and complete External Review request to an IRO to conduct the appeal. The IRO will notify you that it has been assigned to review your claim and will give you the opportunity to submit, within 10 days after receiving the notice, additional information for the IRO to consider. The IRO will forward any information that you submit to the IBM Plan Administrator or the Appeals Administrator for its consideration (or re-consideration).

Within five business days after the External Review request has been assigned to an IRO, the Claims Administrator, Appeals Administrator, and/or IBM must provide to the IRO the documents and any information considered in making the claim denial and appeal denial. If the Claims Administrator, Appeal Administrator or IBM fails to timely provide the information, the IRO may terminate the External Review and reverse the claim or appeal denial in your favor.

The IRO will review all of the information and documents timely received and it will not be bound by any decisions or conclusions reached during the claims and internal appeals processes. The IRO also will, to the extent the information and documents are available and the IRO considers them appropriate, consider other sources of information including, but not limited to, your medical records, your health care professional's recommendations, the terms of the Plan, appropriate practice guidelines, and clinical review criteria.

The IRO will provide, to you and the Plan, written notice of its decision within 45 days after it receives the request for the External Review. Upon receipt of a notice of a final External Review decision reversing the final adverse benefit determination, the Plan will provide coverage or payment for the claim.

Expedited External Appeals.

As soon as possible upon receipt of the request for an expedited External Review, IPRO will complete a preliminary review of your request in order to determine your eligibility for an Expedited External Review. As soon as possible after completion of the preliminary review, IPRO will issue you or your authorized representative a written notification of your eligibility for an Expedited External Review. If your request is complete but not eligible for Expedited External Review, the notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to make the request complete and you will have an opportunity to complete the request.

Upon a determination that a request is eligible for an Expedited External Review, IPRO will assign the request to an IRO for review and will transmit all necessary documents and information to the IRO. The IRO will provide notice to you and the Plan of the final External Review decision as expeditiously as possible, but no later than 72 hours after the IRO receives the request for the Expedited External Review. If the notice is not in writing, the IRO will follow-up with a written decision within 48 hours after providing notice. Upon receipt of a notice of a final External Review decision reversing the decision on internal appeal, the Plan will provide coverage or payment for the claim.

For both Standard and Expedited External Review, please note that the determination of the assigned IRO is final and binding on the Plan, you, and the Claims and Appeals Administrators.

Legal Action

Subject to the limitations described in the "Time Limit on Commencing Litigation and Forum for Litigation" section, below, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the internal appeals process. Before bringing an action, you generally must have submitted both a level-one and level-two appeal for non-urgent care claims and a level-one appeal for urgent care claims and claims under SCCAP. However, if the Claims Administrator, Appeals Administrator, or IBM Plan Administrator fails to follow the internal claims and appeals procedures, in certain circumstances you will be deemed to have exhausted the internal claims and appeals process before receiving a final decision on appeal. If you believe such a failure has occurred, within 60 days of the failure you must notify the administrator your claims and you may request an explanation of whether the violation is insignificant or otherwise would not result in a deemed exhaustion of the internal claims and appeals procedures.

The health plan may also offer you other voluntary alternative dispute resolution options, such as mediation.

Time Limit on Commencing Litigation and Forum for Litigation

No Applicable Claim (as defined in Paragraph (A), below) may be filed in any court or in any other forum until you have exhausted the claims procedures described in the "Claims and Appeals" sections. An Applicable Claim must be filed in a court described in Paragraph (B), below, within the Applicable Limitations Period prescribed by Paragraphs (C) and (D), below. No Applicable Claim may be filed after the Applicable Limitations Period.

(A) An "Applicable Claim" is:

(1) a claim or action to recover benefits allegedly due under the provisions of a plan or plan option covered under this book (hereinafter, a "Plan") or by reason of any law

(2) a claim or action to clarify rights to future benefits under the terms of a Plan

(3) a claim or action to enforce rights under a Plan or

(4) any other claim or action brought by a person who is, seeks to be, or is a successor to a current or former (I) employee (within the meaning of ERISA section 3(6)) of the Company, (II) participant (within the meaning of ERISA section 3(7)), or (III) beneficiary (within the meaning of ERISA section 3(8)) that—

(a) relates to a Plan and

(b) seeks a remedy, ruling, or judgment of any kind against a Plan, the Plan Administrator, the Company, or a fiduciary (within the meaning of ERISA section 3(21)) or a party in interest (within the meaning of ERISA section 3(14)) with respect to the Plan.

(B) A court described in this Paragraph (B) includes one of the following courts:

(1) the United States District Court for the district in which the Plan is principally administered, which is currently New York State

(2) in the case of an action brought by an individual plaintiff, the United States District Court for the district in which the plaintiff resides or

(3) in the case of an action brought by more than one plaintiff, the United States District Court for the district in which the largest number of plaintiffs (or in the case of a putative class action, the district in which the largest number of putative class members) reside (or if that district cannot be determined, the district in which the largest number of class members is reasonably believed to reside).

If an Applicable Claim is filed in a court other than a court described in this Paragraph (B), the Plan, all parties to such action that are related to the Plan (such as Plan fiduciaries, administrators, or parties in interest), and the alleged Plan participants and beneficiaries must take all necessary steps to have the action removed to, transferred to, or re-filed in a court described in this Paragraph (B). This Paragraph (B) is waived if no party invokes it within 120 days of the filing of a putative class action or the assertion of class action allegations.

(C) The "Applicable Limitations Period" for any Applicable Claim will begin on the following date (the "Limitations Start Date"):

(1) In the case of an Applicable Claim to recover benefits allegedly due under the Plan or to clarify rights to future benefits from the Plan, the earliest of (I) the date the first benefit payment was actually made, (II) the date the first benefit payment was allegedly due, or (III) the date the Company, the Plan, or the Plan Administrator first repudiated the alleged obligation to provide such benefits.

(2) In the case of any other Applicable Claim, the earliest date on which you or your beneficiary, if applicable, knew or should have known of the material facts on which such claim or action is based, regardless of whether you or your beneficiary was aware of the legal theory underlying the Applicable Claim.

(D) The Applicable Limitations Period for any Applicable Claim will end on the second anniversary of the Limitations Start Date for such Applicable Claim; provided, however, that if a request for administrative review pursuant to the "Claims and Appeals" sections is pending when the Applicable Limitations Period expires, the deadline for filing such Applicable Claim shall be extended to the date that is 60 calendar days after the final denial (including a deemed denial) of such claim on administrative review.

(E) The Applicable Limitations Period replaces and supersedes any limitations period that otherwise might be deemed applicable under state or federal law in the absence of this Section ("Time Limit on Commencing Litigation and Forum for Litigation"). A claim or action filed after the expiration of the Applicable Limitations Period shall be deemed time-barred, except that:

(1) The Plan Administrator has discretion to extend the Applicable Limitations Period upon a showing of exceptional circumstances that, in the opinion of the Plan Administrator, provide good cause for an extension. The exercise of this discretion is committed solely to the Plan Administrator, and is not subject to review.

(2) The Applicable Limitations Period will apply to a claim governed by section 413 of ERISA only to the extent permitted by law.

(F) In the event an Applicable Claim is brought by or on behalf of two or more claimants, the requirements of this Section ("Time Limit on Commencing Litigation and Forum for Litigation") will apply separately with respect to each claimant.

NOTICE REGARDING IBM'S GRANDFATHERED HEALTH PLANS

The Patient Protection and Affordable Care Act (the Affordable Care Act) states all group health plans in effect on March 23, 2010, may be "grandfathered" plans. A grandfathered plan is exempt from some, but not all, of the requirements under the Affordable Care Act.

IBM believes the IBM Special Care for Children Assistance Plan (SCCAP) is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. A grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential health benefits.

If you have questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, please contact the health plan directly; contact information is available in the Contact Directory on NetBenefits (or on your Health Plan Detail Sheets if you receive print enrollment materials by mail). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 866-444-3272 or dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Chart of Claims Administrators and Appeals Administrators for IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees and IBM Global Assignee Plan -- Subject to the Patient Protection and Affordable Care Act

Health Plan	Claims Administrator	Appeals Administrator
IBM PPO; IBM PPO Plus; IBM EPO; IBM PPO with HSA, IBM Enhanced PPO with HSA		
Anthem Blue Cross and Blue Shield 120 Monument Circle Indianapolis, IN 46204	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348	Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348
Aetna, Inc. Attn: IBM Account Manager 151 Farmington Ave. Hartford, CT 06115	Aetna, Inc. P.O. Box 981109 El Paso, TX 79998-1109	Aetna, Inc. Attn: IBM Appeals Unit P.O. Box 14463 Lexington, KY 40512
IBM PPO; IBM PPO Out-of-Area; IBM PPO Plus; IBM PPO Plus Out-of-Area; IBM EPO; IBM PPO with HSA, IBM Enhanced PPO with HSA; IBM PPO with HSA, IBM Enhanced PPO with HSA Out-of-Area		
UnitedHealthcare Insurance Company 450 Columbus Blvd. Hartford, CT 06115	UnitedHealthcare Insurance Company P.O. Box 740800 Atlanta, GA 30374-0800	UnitedHealthcare Insurance Company P.O. Box 740816 Atlanta, GA 30374-0816
Managed Mental Health Care Program: IBM PPO; IBM PPO Plus; IBM EPO		
Optum 425 Market Street 14th Floor San Francisco, CA 94105	Optum P.O. Box 30755 Salt Lake City, UT 84130-0755	Optum Appeals Department P.O. Box 30512 Salt Lake City, UT 84130-0512

Health Plan	Claims Administrator	Appeals Administrator
IBM Managed Pharmacy Program: IBM PPO; IBM PPO Plus; IBM EPO		
CVS Caremark	CVS Caremark P.O. Box 52136 Phoenix AZ 85072-2136	Appeals Department P.O. Box 52084 Phoenix, AZ 85072-3092
Global Assignee Plan		
Cigna 300 Bellevue Parkway Wilmington, DE 19809	Cigna P.O. Box 15050 Wilmington, DE 19850-5050	Cigna Attn: Appeals Department P.O. Box 15800 Wilmington, DE 19850

Chart of Claims Administrators and Appeals Administrators for all other plans covered by this About Your Benefits booklet -- Subject to the Patient Protection and Affordable Care Act Exempt from or Grandfathered Under the Patient Protection and Affordable Care Act

Health Plan	Claims Administrator	Appeals Administrator
IBM Dental Plus and Dental Basic Plans		
Metropolitan Life Insurance Company One Madison Ave. New York, NY 10010	Metropolitan Life Insurance Company P.O. Box 981282 El Paso, TX 79998-1282	Metropolitan Life Insurance Company P.O. Box 981282 El Paso, TX 79998-1282
IBM Vision Plan and EyeMed Vision Discount Plan		
Anthem BlueView Vision. 555 Middle Creek Parkway Colorado Springs, CO 80921	Anthem BlueView Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111	Anthem BlueView Vision. 555 Middle Creek Parkway Colorado Springs, CO 80921
Flexible Spending Accounts (HCSA and DCSA)		
Acclaris P.O. Box 25171 Lehigh Valley, PA 18002-5171	Acclaris Reimbursement Center P.O. Box 25171 Lehigh Valley, PA 18002-5171	Acclaris Attn: Appeals Review P.O. Box 25171 Lehigh Valley, PA 18002-5171
Adoption Assistance Program		
Acclaris P.O. Box 25171 Lehigh Valley, PA 18002-5171	Acclaris Reimbursement Center P.O. Box 25171 Lehigh Valley, PA 18002-5171	Acclaris Attn: Appeals Review P.O. Box 25171 Lehigh Valley, PA 18002-5171
IBM Special Care for Children Assistance Plan (SCCAP)		
Anthem Blue Cross and Blue Shield 120 Monument Circle Indianapolis, IN 46204	Anthem Blue Cross and Blue Shield P.O. Box 5012 Middletown, NY 10940-9021	Anthem Blue Cross and Blue Shield P.O. Box 5012 Middletown, NY 10940-9021

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), is an order issued by a state court or agency which requires the non-custodial parent (IBM employee), who does not have custody of his or her natural or adopted children, to provide medical coverage for the children under the IBM group health plans and pay the premiums related to the child's enrollment. The order allows the custodial parent to act on the child's behalf by speaking to the benefits carrier to discuss claims, select a primary care physician (PCP) and request the benefits cards sent to the child's home address.

Once the IBM Benefits Center – Provided by Fidelity approves or qualifies the Order as meeting ERISA guidelines, IBM is required by law to enroll the child (if not currently enrolled) in the employee's health plans and advise all benefits Plan Administrators of the child's enrollment and the named alternate payee (custodial parent) for the child. Based on the order, benefits may be paid directly to a named alternate payee (custodial parent), or to a legal guardian of the child, including a child support enforcement agency.

If you have been designated as an alternate payee in the order, please contact the IBM Benefits Center for any questions or information you need regarding the QMCSO. For further information regarding QMCSOs you may also view the U.S. Department of Labor's compliance guide at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf.

YOUR RIGHTS UNDER ERISA

On September 2, 1974, the Employee Retirement Income Security Act of 1974 ("ERISA") was enacted, establishing federal controls over most employee pension and welfare benefit Plans. As a participant in the plans covered in this book, you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report for plans that are required to have such a report. The Plan Administrator is required by law to furnish each participant with a copy of this annual summary report for plans that are required to have such a report.

Continue Group Health Care

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans covered in this book which are governed by ERISA. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a welfare benefit is ignored or denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. You cannot sell, transfer or assign the value of your benefit under the health plan.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is ignored or denied, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMSCO), you may file suit in federal court.

If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration at:

Division of Technical Assistance and Inquiries, Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

It is anticipated that most questions can be answered by the IBM Benefits Center – Provided by Fidelity.

YOUR RIGHTS UNDER NMHPA

The Newborns' and Mothers' Health Protection Act provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that provider to obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

YOUR RIGHTS UNDER WHCRA

The Women's Health and Cancer Rights Act (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy to provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copayments and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable IBM Medical Plan option. Please refer to the applicable At-A-Glance chart for information regarding deductibles, copayments and coinsurance under the IBM Medical Plan option in which you are enrolled.

For information regarding the HMO options, please contact the HMO directly. If you would like more information on the Women's Health and Cancer Rights Act benefits, call the IBM Benefits Center.

YOUR RIGHTS UNDER USERRA

If you are serving in the military and are covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you will continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

PLAN DISCLOSURE INFORMATION

ERISA also requires companies to disclose certain detailed information to you so that you have it available for reference purposes. If you need additional information, you are encouraged to call the IBM Benefits Center – Provided by Fidelity. If you have questions regarding coverage and claim payments, you can obtain more information from the individual Claim Administrators.

Plan Year

The records of all of the plans covered in this book are kept on a calendar-year basis, beginning January 1st and ending December 31st of each year, which is in each case, the plan year.

Plan Sponsor

The plans covered in this book are sponsored and maintained by International Business Machines Corporation. The Plans covered in this book have been established by International Business Machines Corporation, Armonk, NY. The Employer Identification Number (EIN) assigned to IBM is #13-0871985.

Plan Administrator

The Plan Administrator for each of the plans covered in this book is a committee which consists of three or more executive level employees appointed by action of the IBM Retirement Plans Committee. The address for the Plan Administrator is:

Office of the Plan Administrator
IBM Benefits Center – Provided by Fidelity
PO Box 770003
Cincinnati, OH 45277-1060

Telephone: 866-937-0720 (TTY: 800-426-6537); outside the U.S. call 919-784-8646.

Agent for Service of Legal Process
Service of legal process may be made upon the Plan Administrator.

Plan Funding and Administration
The IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees is self-funded and fully insured and regulated by federal law. The role of the insurance companies that administer the individual medical options within the Plan is not to insure the Plan but to provide administrative services under contracts with IBM and the Plan. These companies are referred to in this booklet as "health plan" or "plan administrator." Eligibility for coverage of dependents, health care providers, facilities and treatments and supplies is determined solely by the provisions of the Plan. State or local laws mandating coverage for certain dependents, providers, facilities, treatments, etc., do not apply to the Plan. Final discretion and authority to interpret the provisions of the Plan rest with the Plan Administrator.

See the chart below of the funding and administration of the other plans covered by this booklet.

Trustee for the IBM Medical and Dental Benefits Plan for Regular Full-time and Part-time Employees
The Plan trustee is:

JPMorgan Chase Bank
4 New York Plaza, 17th Floor
New York, NY 10004

RIGHT TO MODIFY OR TERMINATE IBM BENEFIT PLANS

IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the Company requires. Nothing contained in this book shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies.

IBM's benefit plans may be amended by written resolution of the Board of Directors or any Committee to which the Board has delegated power. The Retirement Plans Committee is authorized to amend any plan which is funded through a trust, including the IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees. All other benefit plans may be amended by the IBM chief human resources officer or other IBM executive by means of a written instrument, such as the text of a plan, a summary plan description, a trust agreement, an insurance contract or insurance certificate, an administrative services contract, the administrative documents and procedures for a plan, an electronic medium notice, a hard copy bulletin board notice or an announcement letter or written materials that are approved by said chief human resources officer or other IBM executive and maintained with the records of the affected benefit plan.

PLAN FUNDING AND ADMINISTRATION CHART

Official Plan Name and Type	Plan Number	Type of Administration	Benefits Type	Claims Administrator	Funding
Plan Name: IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees Plan Type: Medical	519	Plan Administration and Contract Administration	▪ IBM PPO ▪ IBM PPO Plus ▪ IBM EPO ▪ IBM PPO with HSA ▪ IBM Enhanced PPO with HSA	Anthem Blue Cross and Blue Shield Aetna, Inc.	Self-insured by IBM and funded by employee and employer contributions
			▪ IBM PPO ▪ IBM PPO Out-of-Area ▪ IBM PPO Plus ▪ IBM PPO Plus Out-of-Area ▪ IBM EPO ▪ IBM PPO with HSA ▪ IBM PPO with HSA Out-of-Area ▪ IBM Enhanced PPO with HSA ▪ IBM Enhanced PPO with HSA Out-of-Area	UnitedHealthcare Insurance Company	
			Managed Mental Health Care Program	Optum Health	
			IBM Managed Pharmacy Program	CVS Caremark	
			Health Care Spending Account	Acclaris	
			Special Care for Children Assistance Plan	Anthem Blue Cross and Blue Shield	
			Dental Plus and Dental Basic	Metropolitan Life Insurance Company	Fully Insured
Plan Name: IBM Vision Plan EyeMed Vision Discount Plan Plan Type: Vision Care		Plan Administration and Contract Administration		Anthem BlueView Vision EyeMed Vision	Fully Insured
Plan Name: IBM Special Care for Children Assistance Plan Plan Type: Special Care	508	Plan Administration and Contract Administration			Self-insured by IBM with no employee contributions